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The Impact of Adolescent Psychopathology, Family Dysfunction and Stress on Adolescent Termination from Therapy

by

Corinth I. Lewis

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THE UNIVERSITY OF ALBERTA FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommended to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled THE IMPACT OF ADOLESCENT PSYCHOPATHOLOGY, FAMILY DYSFUNCTION AND STRESS ON ADOLESCENT TERMINATION FROM THERAPY submitted by CORINTH IRENE LEWIS in partial fulfilment of the requirements for the degree
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DEDICATION

To my mother, who gave me all she had to give and imbued me with the will to be the best I could be, and to my husband, Victor, my lifelong friend and my beloved children Omari and Micere.

ABSTRACT

The problem of termination from treatment by patients after therapy has been instituted continues to generate feelings of failure and frustration in clinicians. In an attempt to determine if there were variables that were differentially indicative of families and patients who successfully completed therapy and those who did not, a systematic investigation was undertaken at an Adolescent Day Treatment Program. The families were studied retrospectively using data from standardized self-report instruments which assessed family functioning, adolescent behaviour problems and psychopathology. Additional data relating to family stressors were obtained from charted progress notes. The two groups, N = 20, of dropouts and N = 20, of completers, were compared within and across samples. Results were obtained which endorsed dropouts as experiencing more severe levels of dysfunction and experiencing higher levels and a greater multiplicity of stressors, and as having adolescent patients with more chronic histories of problems than completers. Of the twenty dropout families, sixteen had significant martial conflict compared to eleven in the sample of completers. In the families of dropouts, abuse was present in twelve of the dropout families compared to three in the families of completers. Parents of dropouts endorsed Externalizing behaviours of their adolescents as more problematic than parents of completers, while parents of completers endorsed Internalizing behaviours of their adolescents as more problematic than parents of dropouts. Dropouts produced a profile typical of enmeshed familes while this pattern was not as pronounced for families of completers.

These findings are discussed in terms of recommendations for management and treatment of these families that could reduce the dropout phenomenon.

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I. INTRODUCTION

The behavior that an individual manifests in response to environmental stress may be viewed on a continuum from adaptive and relatively healthy coping behavior to the more extreme examples of ineffective efforts to meet the demands of stress. The more successful efforts to cope have been seen as examples of adaptive behavior. Such coping responses have been studied in terms of problem-solving, competency, and mastery processes. They are typically seen as instances of active, goal-oriented effort, with some perceptual-cognitive element involved.

At the other extreme are the more clearly inadequate and inappropriate attempts to respond to stress. These are studied under the domain of psychopathology since they often result in behavior that is not only ineffective but often counterproductive, that is, against the individual's own best interests. When the individual is an adolescent, such behavior is seen as problematic by parents, teachers, and other adults. It has a negative impact on school, work, peer relations, and the family. Both ends of the continuum represent efforts to cope. It is usually the latter, the ineffective and counterproductive behaviors of adolescents that bring them to the attention of adults and eventually to mental health professionals.

Inconsistencies in the Research Literature

However, a problem faced by mental health professionals once therapy is instituted, is the self-termination of patients. This problem is coterminous with the very beginning of dynamic psychotherapy. One of the first published case presentations was that of Dora, an adolescent who terminated

prematurely (Freud, 1905). Since then a number of studies have examined the process of attrition in psychiatry clinics (Cohen & Richardson, 1970; Ewalt et al., 1972; Fischer, 1975; Gaines, 1978; Ross & Lacey, 1961). Factors studied have included sex and age of the child (Cohen & Richardson, 1970; Ewalt et al., 1972), socioeconomic status of the family as well as other demographic descriptors (Cohen & Richardson, 1970; Ewalt et al., 1972; Fischer, 1975; Gaines, 1978), referral source (Cohen & Richardson, 1970; Gaines, 1978), clinical descriptions of the child (Cohen & Richardson, 1970; Cole & Magnussen, 1967; Levitt, 1958), treatment characteristics (Cohen & Richardson, 1970; Cole & Magnussen, 1967), and parental attitudes toward the child or toward treatment (Cohen & Richardson, 1970). One basic difficulty in comparing the findings and dropout rates reported by the various studies is that attrition occurred at different phases of the clinic process: i.e. intake, diagnostic/evaluation, or treatment phase.

Another problem in arriving at a definitive picture of the adolescent who terminates treatment prematurely results from the assessment procedures employed. Standardized interviews or questionnaires have rarely been administered (McAdoo & Roeske, 1973). Rather, case record reviews have been employed in many of the studies (Cohen & Richardson, 1970; Cole & Magnussen, 1967). Thus the assessment techniques often preclude any analyses on other than the most basic demographic descriptors (Tuckman & Lavell, 1959; Williams & Pollack, 1964). Furthermore, clinical descriptions of the adolescents cannot be compared since different symptoms and diagnostic factors have been evaluated (Cohen & Richardson, 1970; Singh et al., 1982). Finally the assessment period has varied. Information has been obtained from initial evaluations (Ewalt et al., 1972; Fischer, 1975; Gaines, 1978; Lake &

Levinger, 1960; Singh et al., 1982), from termination records (Ross and Lacey, 1961), as well as from interviews at some time after the patient dropped out (Farley et al., 1975).

Given the different methods and definitions of attrition that have been employed, it is not surprising that the results of those studies that are capable of comparison (e.g. demographic factors), have often been contradictory. For example, while many studies have reported no significant differences between attenders and terminators in relation to social class (Cohen & Richardson, 1970; Ewalt et al., 1972; Gaines, 1978), others have reported that self-termination is related to lower socioeconomic levels (Lake & Levinger, 1960), or to higher socioeconomic levels (Singh et al., 1982). Many investigators have reported a significant relationship between self-termination and referral source (Lake & Levinger, 1960; Ross & Lacey, 1961; Williams & Pollack, 1964), yet, a lack of an association has also been found (Cohen & Richardson, 1970; Gaines, 1978).

The Impact of Parental Motivation

In contrast to these inconsistent findings, there is general agreement that in child psychiatry clinics, the motivation of parents appears to be a crucial factor in differentiating between completers and terminators (Cohen & Richardson, 1970; Ross & Lacey, 1961). When, for whatever reason, parental motivation is seriously jeopardized, it follows that the potential for discontinuation of therapy would become greater. Hofstein (1957) has pointed out that assessment of a child's treatability must rest on the evaluation of the parents' capacity to involve themselves in the treatment process and to work towards change in their relations to each other as well as to their child.

The important contribution of parental attitudes to continuation in therapy has also been stressed by Inman (1956) and Smigelsky (1949).

Lake and Levinger (1960) found differences in parental attitudes when they compared 50 continuers with 50 discontinuers. The parents of continuers tended to be more aware of their child's disturbance and of their own contribution to it. They were more inclined to see the problem as something for which the family as a whole was responsible and accepted that they themselves had to participate in finding a solution. They also displayed greater co-operation during interviews and tended to agree with the therapist on the nature of the child's disturbance. Despite the importance of parental factors such as motivation and commitment, this writer has found only two studies that have examined the personality characteristics of the parents (McAdoo & Roeske, 1973; Gould et al., 1985). One other study conducted a retrospective review of the social history information to identify the presence of psychiatric illness in the parents (Singh et al., 1982). To date, differences in the symptomatology of the parents of adolescents who terminate treatment prematurely and those who complete treatment have been addressed in only one known study (Gould et al., 1985), and these researchers examined the problems of "dropouts" from the intake process.

Social Support as a Buffer

Ideas in support of a relationship between social support and psychopathology come from several different bodies of psychological theory. Attachment theory, exemplified by the writings of Bowlby (1960), as well as empirical research (Ainsworth, 1967; Strayhorn, 1980), suggests that losses during early childhood of significant members in an individual's support

system can result in psychological impairment. Systems theory, exemplified by the writings of family systems theorists, predicts that individuals who belong to poorly functioning support systems that are experiencing unresolved conflict are at high risk for emotional disturbance (Bowen, 1978; Hoffman, 1981). In addition, authors and clinicians interested in preventative or community psychiatry have proposed that social support systems "act as a buffer against disease" (Caplan, 1974).

This hypothesized relationship between psychopathology and social support has been subject to extensive empirical investigation. Much of the research in this area has investigated the role of stressful life events in physical and mental health, with social support being viewed as a buffer or mediating variable. Studies in which social support is seen as an independent variable have shown that it is related to a variety of dependent variables, including psychiatric hospitalization, posthospitalization adjustment, primary prevention of mental illness, and maintenance of mental health, and the development of psychiatric syndromes or symptomatology (Greenblatt, Becerra, & Serafetinides, 1982). In general, this study indicates that people with lower levels of social support are at higher risk for the development of psychiatric symptomatology.

Initial Findings

The present study is in part a replication of the study done by Gould et al., (1985) which examined the relationship between dropouts from the intake process of a child psychiatry clinic and the child and caretakers' symptomatology, the socio-demographic characteristics of the family, and characteristics of the clinic and referral sources. The sample for the study,

which was done in New York, was obtained over a sixteen month period at a clinic which had several sub-speciality clinics. The age of the clients, both male and female, ranged from 4 to 16 years and was largely represented by the three dominant ethnic groups -- white, black and Hispanic. Of the research sample who attended the initial screening appointment 11% failed to attend their next scheduled appointment, 63.2% were males, 15.8% were white, 26.3% black and 57.9% Hispanic. The researchers used these cases as the sample of index cases ("dropouts"). "Attenders" were those cases who returned for the evaluation interview which followed the initial screening interview. Starting or staying in treatment was not a factor in distinguishing "attenders".

The questions the researchers addressed sought to identify characteristics that differentiated attenders from non-attenders and explored the relationship between non-attendance and (a) the child's symptomatology, (b) the caretakers' symptomatology, (c) the socio-demographic characteristics of the family, (d) characteristics of the clinic and (e) the referral sources. Whether or not these factors in combination interacted to influence dropping out was also examined.

Psychiatric symptomatology in the children and their parents' and the socio-demographic characteristics of the family was assessed using standardized instruments and a demographic form. A self-completion questionnaire was also administered to the dropouts to determine the decisions that influenced their (dropping out) failure to return for the evaluation interview.

In analyzing the results of their study the researchers found that (a) the dropout rate in the clinic was lower than most rates reported in the literature; this they attributed to the "phase of attrition" they studied ie: dropping out

immediately after their first attendance at the clinic, (b) dropping out was more common among school referrals; this was consistent with other research eg: Lake and Levinger (1960) and Williams and Pollack (1964), (c) there was no difference between dropouts and attenders on measures of socio-economic status; this finding is supported by the majority of research examining this characteristic, (d) sex, age and racial differences showed no relationship to dropping out; in the literature research into these factors have been contradictory, (e) there was no difference between the psychopathology of dropouts and attenders; these results could not be compared with other research since in the latter standardized assessment instruments were not employed, (f) disturbance in the parents of those adolescents who dropped out was greater than disturbance in the parents of those adolescents who returned; this significant finding contradicted the one other study that examined the presence of psychiatric illness in the parents (Singh et. al. 1982). However, assessment procedures and phase of attrition in the two studies were different.

The Need for Further Exploration

It is the intention of this researcher to attempt to contribute to the relatively unexplored area of non-therapeutic termination of therapy of adolescents and the extent to which family dysfunction and discord during the treatment phase impacts on the dropping out process.

The adolescent population has, historically, been identified as one of the most difficult to work with in therapy. This is due in part to what is perceived as the combined effect of psychiatric dysfunction at a time when, according to Blos (1970),

> ". . . the more-or-less orderly course of development during latency is thrown into disarray with the child's entry into adolescence . . . adolescence cannot take its normal course without regression. (pg. 11)".

Adolescence is the age period when there is supposed to be an "identity crisis". As they achieve increasing autonomy and independence from their family of origin, youngsters struggle to achieve a sense of their own distinct personality. It is said that adolescents generally become increasingly estranged from their families and that parents complain that they can no longer "get through" to their children. Erickson (1955) has described identity formation as the main characteristic of adolescence. During this period of development the childhood identifications cease to be useful and a new configuration has to develop. The crisis at this point may lead to "role confusion" or "identify diffusion". He writes,

> ". . . in spite of the similarity of adolescent 'symptoms' and episodes to neurotic and psychotic symptoms and episodes, adolescence is not an affliction, but a *normative crisis*, ie: a normal phase of increased conflict characterized by a seeming fluctuation in eg: strength . . . what under prejudiced scrutiny may appear to be the onset of a neurosis, often is but an aggravated crisis which might prove to be self-liquidating and, in fact, contributive to the process of identity formation."

A beginning step has been undertaken in this study to increase the efficacy of treatment to adolescents living with their families who have been given a psychiatric diagnosis and who, subsequent to the institution of therapy, dropped out non-therapeutically. An attempt has been made to identify the conditions and events associated with the dropping out process. As was indicated earlier, research efforts in this area with an adolescent population is limited, and this writer has found no study in which the examination of the effect of familial stressors on the dropping out process has been investigated.

This writer has been particularly interested in the predictive power of familial dysfunction (psychopathology) and discord; in combination these factors have been observed to significantly influence the course of therapy including the termination of treatment of the adolescent identified as the patient.

In an attempt to add to our understanding of factors which contribute to non-therapeutic termination of adolescents, this writer examined data from the charts of twenty teenage "dropouts" and twenty "completers" who were in treatment at a Day Program for adolescents. Data were obtained from standardized and demographic questionnaires and progress notes and included salient information on both patients and their parents. Each child in the study lived at home with both parents. The sample of "dropouts" was compared with the sample of "completers" on the basis of (a) patient psychopathology, (b) family dysfunction and (c) response of patient and parents to stressors at critical points during treatment.

The Problem and its Setting

The study that has been undertaken in this thesis evolved out of this researcher's interest and current career involvement in Group Therapy with adolescents. The goal is to learn more about the characteristics of adolescents in treatment and their families that can provide information that will enhance the selection criteria. To the extent that this is achieved provision of service becomes more cost-effective; and for those patients in treatment such information could serve to alert treatment staff to potential difficulties before they arise, thereby increasing the probability of successful treatment outcome.

Rationale

Much of the research in psychotherapy is organized between pure empiricism on the one hand and rigorous experimentation on the other. This researcher is taking a stand which is between these two extremes and represents a commitment to what Maslow (1946) and Murray (1938) originally termed a "problem-centred" in contrast to a "method-centred" point of view for research. The focus is upon one of the problems in psychotherapy of concern in the daily work of mental health professionals engaged in active treatment of adolescents - that of non-therapeutic termination from treatment. To achieve this required an approach that gave this researcher room to manipulate, co-ordinate and investigate variables. This imposed certain pragmatic limitations in the choice of method - specifically that this researcher makes maximum use of the usual information sources i.e. clinical records, case histories, conference and progress notes, information from family interviews and diagnostic and research tests. The study is, in other words, closely integrated with clinical functions.

The Major Research Problems

To complete the study required analysis of identifiable personal and situational variables of a select number of adolescents who terminated treatment non-therapeutically, referred to as "dropouts", and a corresponding number of adolescents who received a therapeutic discharge, referred to as "completers". An attempt is made to determine those variables that are predictive of treatment termination. Variables associated with the families of the adolescents in the study are also analyzed. Factors in the patients' personality organization and in the structure and dynamics of his illness are

measured on the Child Behavior Checklist (CBCL) (Achenbach, 1978; Achenbach & Edelbrock, 1981), and the Symptom Checklist - 90 (SCL-90R) Derigatis, 1977). Family functioning is measured using the Family Assessment Device (FAD) (Miller, Epstein, Bishop & Keitner, 1984).

The Sub-Problems

The first sub-problem was to assess the extent to which perceived stress and family dysfunction are associated with treatment termination. The second sub-problem was to assess the extent to which family dysfunction and chronicity of adolescent psychopathology are associated with treatment termination. Data collection and method of analysis were varied slightly in accordance with the sub-problems being investigated; the observation points, however, were fairly uniform for all. These were set at the time of initial assessment of the patient and his family, upon termination of treatment whether therapeutic or non-therapeutic, and at critical points during the course of treatment. Data were obtained from the entire chart of all subjects in the study.

Definitions:

Dysfunction: In family systems this has been explained as a relation among three entities - 1) anomalies in the family system's makeup (differentiation and adaptability); briefly: *underlying anomalies*; 2) disorders in internal operation, manifested in distortions in information processing; briefly: *operation disorders*; and 3) inadequate task-performance; briefly: *malfunctioning*. The underlying anomalies are said to *breed* operation disorders and the latter to *interfere with* proper functioning. This view of

family dysfunction has been incorporated, fully or partially, explicitly or implicitly in numerous studies of family systems theory and therapy (Aldous et al., 1971; Byng-Hall, 1980; Gilbert et al., 1984; Minuchin, 1974; Olson et al., 1979; Wertheim, 1975).

Stress in this study is defined as a change or threat of change demanding adaptation by the family. The stimulus for this change is called a *stressor*, and the adaptation is described in terms of behavioural (in this study continuing therapy or dropping out) responses. Variables interposed between the stressors and adaptation involve personality variables including perceptual and behavioural response *(coping)* styles (Dohrenwend & Dohrenwend, 1974; Holmes and Rahe, 1967; Seleye, 1956).

Overview of the Study

Crucial to the study and understanding of the outcome of therapy with adolescents is the role played by the family in which these adolescents live. The family is the place where crucial needs of children are both created and satisfied; it is the place, too, where conceptions about themselves, both as they are and as they would like to be, begin to take shape.. As such the family is crucial to the social and emotional life of the children and adolescents.

Thus, in spite of the exaggerated need for independence and control typically displayed by adolescents, researchers have found that the overwhelming majority of teenagers report feeling close to and want to continue a lifelong relationship with their parents (Maccoby and Martine, 1983; Offer, Ostrov, and Howard, 1981). Adolescents exhibiting dysfunctional behaviour patterns tend to come from homes where the parent's relationship is disturbed (Olson, 1970) and the environment is stressful. Adolescents in low

quality marriages are generally confronted by a family atmosphere where members have high levels of misperceptions and misunderstandings of each other's behaviour. The misperceptions of adolescents, like those of their parents, are likely to add to their unhappiness and dissatisfaction. In the course of therapy areas of dysfunction within the family unit are eventually identified by one or more family members often generating additional stress. The level of family functioning and response repertory provide crucial indicators of the choice of action the family and/or individual members are likely to take in dealing with the stress.

The family is also a mediating force in the stress process; that is, it is a place where individual members can find the resources to deal with stress whatever its source. These resources are *social supplies* and *coping repertories*. The latter are, in part, the product of a family screening system that encourages some coping modes and discourages others.

In the following chapter efforts are directed towards (a) the identification of familial origins of stress, (b) a discussion of the impact of stress on children and adolescents, (c) a review of the coping patterns of adolescents and their parents, and (d) an analysis of issues relevant to the sample of adolescents in this study.

II. REVIEW OF THE RELATED LITERATURE

A. Stress and Dysfunction - Implications for the Child and His Family

Theories of Stress

Several stress theories bear on the conceptualization of support. An understanding of these relationships is crucial in assessing the ways in which individuals and families (systems) respond. Three of the most basic focus on needs, transactions, and transitions. Each of these will be discussed separately.

The *needs* model of stress postulates that individuals have needs that are met through interaction with other persons in a variety of social relationships that if unmet are experienced as sources of distress. Caplan (1964) offered an early formulation of this point of view in which he argued that (1) a person must have *supplies*, (2) the "provision of supplies" is equivalent to the "satisfaction of interpersonal needs", and (3) "inadequate provision of psychosocial supplies . . . is conducive to mental disorder". Weiss (1974), following Caplan, wrote about the "provisions of social relationships", claiming that individuals' needs or requirements for well-being are met through social relationships, and that relationships are specialized for what they provide. For example, in Weiss' analysis, the need for attachment is met through marriage; the need for social integration, through friends; the need for nurturance, through parenting; and the need for guidance, through experts and professionals. Other researchers postulate different needs; for example, the maintenance and enhancement of "self-regard", "self-esteem" and "mastery" (Pearlin, Menaghan, Lieberman and Mullan 1981; Pearlin, 1983). Weiss

(1974) hypothesize that the absence of need-satisfying relationships leads to distress, the form of which will be specific for the relational deficit. In Weiss' (1973) view, the absence of a loved one and the absence of friends, which he describes respectively as emotional and social loneliness, are especially stressful. Henderson and his associates (1981, 1982) agrees.

In the *transactions* model of stress, stress occurs when perceived demands exceed perceived resources, with ensuing negative consequences for the individual's well-being (McGrath 1970; Lazarus and Launier 1978). In the transactional view, any demand which exceeds the individual's resources may cause stress. Such demands may occur as discrete life events and/or as continuing low-keyed hardships; namely, daily hassles or persistent life strains (Lazarus 1981; Pearlin et al, 1981; Pearlin 1983). It is not the nature of the event that matters (whether it is major or minor, acute or chronic), but rather its significance as a demand which exceeds the individual's response capacity.

In the *transitions* model of stress, stress is seen as stemming from changes -- both losses and gains -- or "psychosocial transitions". *Psychosocial transition*, according to Parkes (1971) is a relatively abrupt change in a person or in his environment which affects the individual's assumptions about the world and his or her place in it (Bowlby 1969, 1973, 1980; Brown 1974, 1982). These assumptions or "structures of meaning" (Marris, 1982), enable individuals to understand the world and to interpret their experiences in it. they give meaning to experience (past, present and future). Central to this view is the idea that (1) these assumptions shape behavior (Frank 1961), and (2) events that challenge or change these assumption (a) undermine the individual's sense of meaning and (b) are experienced as stressful. Not only is the event stressful, but also the readjustment in the individual's assumptive

world which it requires. Change encompasses not only external circumstances, but more importantly, perception of the world. Existential change may be sudden, but cognitive change will be slower.

Although these models of stress are analytically distinguishable, they overlap conceptually. For example, the transactional and transitional model of stress both consider the role of appraisal and the attribution of meaning in defining stressors. In the transactional model, an individual's "beliefs" are said to determine the significance of an event, including its stressfulness. Pearlin (1983) writes that beliefs:

> are preexisting notions about reality which serve as a perceptual lens or a *set* . . . . determine which is fact, that, is 'how things are' in the environment, and they shape the understanding of its meaning (p. 18).

Such "beliefs" are analogous to the "assumptions" that constitute the "assumptive world" of transitionalists, and both are closely related to the notion of a "contextual threat", which is central to the work of Brown and his associates (Brown 1974; Brown and Harris 1978; Brown 1982). All of these concepts: "beliefs", "assumptions", and "contextual threats", refer to the significance, meaning or implications that an event or demand has for the individual's well-being.

Theories of Coping

The theoretical formulations that have contributed to the study of coping [illegible] from several sources. Psychoanalytic and ego psychologists have been led to adaptation and coping through the exploration of such ego functions as perception, language, memory, and thinking; processes that

enable the individual to master and alter the environment (White, 1976). Haan (1977) reflects an ego psychologist's perspective in describing coping as an ego process that involves purpose, choices, flexibility, and adherence to consensual reality and logic.

Other theorists have taken a cognitive-behavioural approach, emphasizing the social learning and problem- solving aspects of coping (Kendall and Hollon, 1980). One of the better definitions of coping comes from Lazarus and Launier (1978), who define it as:

> efforts, both action oriented and intrapsychic, to manage (that is, to master, tolerate, reduce, minimize) environmental and internal demands and conflicts among them which exceed a person's resources. (p. 311)

Pearlin and Schooler (1978) classified the responses they identified into three functional groups: (1) those which altered the situation generating the stress, (2) those which created more congenial perceptions of problematic experiences, and (3) those which function more in managing existing stress. The most common type of coping response is the second - those where the response functions to control the meaning of the situation. They refer to this as "cognitively neutralizing" the threat.

In an effort towards identifying and classifying coping responses Moos and Billings (1982) have proposed a preliminary taxonomy based on rational categorization. Their taxonomy divides nine common coping responses into three domains: (1) *Appraisal-focused coping* (logical analysis, cognitive redefinition, cognitive avoidance); (2) *Problem-focused coping* (seeking information or advice, taking problem-solving action, developing alternative rewards); and (3) *Emotion-focused coping* (affective regulation, resigned

acceptance, emotional discharge). These categories are not mutually exclusive, nor do they exhaust the possibilities, but it is likely, as the authors contend, that they represent the major types of responses employed.

Lazarus and Coyne (1980) have emphasized the cognitive elements in coping which involves the appraisal of the event or situation. Their findings demonstrated stressful events can be considerably more benign through cognitive means of achieving emotional control. Cognitive appraisal refers to the person's "continually reevaluated judgments about demands and constraints in ongoing transactions with the environment and his own resources and options for managing them" (Coyne and Lazarus, 1980, p. 150). Cognitive appraisal, as can be seen from Lazarus' definition of coping given above, is an integral part of coping. This cognitive process is of crucial importance in discussing the coping efforts of adolescents whose cognitive development is limited.

Adolescents are limited in their responses by cognitive and language development, social maturity, and a lack of life experiences (previous learning) which results in fewer responses in their repertoires. Adolescents lack the adult reasoning powers that come with maturity. Thus, developmental considerations serve to restrict the responses available to them.

Added to these developmental limitations are a number of other realistic restraints, such as a relative lack of mobility, financial and personal dependence on the family, home, and significant adults, all of which serve to limit their freedom to act in dealing with stress.

Transactional theorists view coping with stress as a process that involves different types of support at different times and reflects the continuous development of appraisals and reappraisals of the shifting

relationship between an individual and the changing demands made upon him or her. Folkman and Lazarus (1985) developed the differential use of social supports at different stages of coping with stresses. Heller and Swindle (1983), suggest that different supports may be appropriate in (1) anticipation of a stressful event, (2) concurrent with that event, and (3) following the event.

In the transitionalists' view stress is linked to a person's assumptive world and to the process by which an individual replaces one set of ideas, beliefs and values with another. While transactionalists are partly concerned with the temporal dimension of support, transitionalists see support almost exclusively in this dimension. They argue that in the process of resolving or adjusting to stress individuals typically look backwards to their past lives and do not begin to look forward to the reorganization of their lives until they have given up the idea of that which they have lost. Until individuals reach that turning point, advice or information about how they could or should lead their lives -- no matter how well-meant or supportive it was intended to be -- often is unheard or unheeded. This process is believed to occur in steps, stages, or phases, and support is construed as a matter of timing. The timing of support is therefore linked with the process of coping and with "coping stages" that occur over time.

Although the concept of coping stages is controversial, it is a useful construct. Silver and Wortman (1980) and Lazarus and Folkman (1984) have reviewed different models of coping stages and found that the evidence for them is problematic because people's responses to stressful situations appear to vary. As both Silver and Wortman (1980) and Lazarus and Folkman (1984) note, however, that variability does not necessarily obviate the utility of stage models. This is especially true if stage models (1) are understood as analytical

constructs or ideal types rather than regarded as normative guidelines and (2) are used to both examine support as a process and identify factors that appear to alter this process. Finally, a stage model is useful to the extent that it (1) postulates that an individual's reaction to a stressful situation typically changes over time, and (2) focuses attention on (a) variations from that expected course and (b) the conditions under which they occur. Variables, such as social support, that moderate individual coping responses are precisely what are to be expected as sources of different adaptational outcomes.

Two other arguments explain possible sources of variation in response to stressful experiences and thereby urge caution in the use of stage models. Recursive models (Lazarus et al. 1985) which entail an interplay between appraisals of well-being and appraisals of coping options, suggest that because the perception of an event may change over time, behavioral differences in relation to it can be accounted for by shifts in attributed meaning rather than by the absence of progressive stages. Alternatively, it is possible, as Silver and Wortman (1980) indicate in their discussion of Klinger's (1977) "incentive-disengagement" stage model, that different stages may overlap or co-occur -- each generating different attempts to manage or cope -- thereby obscuring the sequence of coping stages and the temporal framework within which they occur.

Maladaptive Responses of Adolescents to Stress

Coping responses have varying degrees of effectiveness with some attempts clearly ineffective. These are often socially unacceptable, extreme examples of coping behavior. In some cases they may be partially successful in meeting the demands of the primary stressor, but in the process, they create a

new set of secondary stressors with which the individual will further have to cope.

Klerman (1979) sees adult depressive episodes as vain attempts on the part of the individual to cope. Clinical depressions are, from his adaptational perspective, maladaptive outcomes of partially successful efforts at adaptation. In a similar way, adolescent behavior disorders or emotional adjustment problems may also be seen as maladaptive attempts to cope with stress. The extreme responses adopted by adolescents are manifested in behaviors that call attention to themselves and interfere with effective functioning at home, in school and in social relations. It is these behaviors or symptoms that cause an adolescent to be brought for treatment.

Internalizing and Externalizing Patterns of Behavior

While there is considerable variation in the ways individuals may respond to stress, depending on personality, social, and cultural factors, the range of human responses is not infinite. Ultimately, human nature restricts the options that are available to the individual, and genetic factors and previous learning further limit them to a rather fixed repertoire for any one individual. As a result, response patterns may follow a few basic themes, although there may be a number of variations on those themes.

Man is a dynamic entity. He must reach out to interact with his environment in order to ensure survival. Some degree of activity is always present. Physiological studies have shown that the degree of activity is related to, among other things, the state of physiological arousal of the nervous system (Duffy, 1962). Activity serves as one of the underlying dimensions of personality.

The second dimension reflects the direction toward which activity is expended. Some individuals tend to turn their activity towards the world. They are allocentric, outward-looking, and overtly active. These extroverts represent one end of a continuum, with the more introverted withdrawn individuals at the other. Jung (1928) is often credited with having introduced this dimension to the study of personality, and it has become one of the most popular dimensions used by personality theorists (Levy, 1970).

In assessing the response patterns of adolescents, parents' in-depth knowledge of a child often makes him or her sensitive to nuances of the child's behavior or internal feeling states that will not be apparent to an objective observer (Mash and Johnston 1983; Reich et al. 1982). Conversely, externalizing behaviors, because they are overt and can be readily observed, show higher correlation when reported by parents and objective observers. The literature also cites that in reports of parents versus children, the best correlations were between parents' reporting of children's external troubling behaviors obviously noticeable and worrisome to the parent, and children's reports of internal depressed or anxious feelings (painful to the child but not always obvious to the parent). Thus, the degree of correlation between the perception each parent has of the child and the child's perception of him- or her-self has implications for the functioning of the family as a unit.

Research into Response to Stress

Concerns regarding the effect of stressful events on the psychological and behavioral responses of individuals was observed and recorded by theorists as early as 1928 when Sigmund Freud, in Europe, pointed to the many similarities between the victims of "shell shock," and those of accidents

and disasters. Followers of Freud and others later studied the psychological stress associated with war (Grinkler and Spiegel, 1945), family disruption (Freud and Burlingham, 1943), accidents and disasters (Kinston and Rosser, 1947), and concentration camp experiences (Bettelheim, 1960).

From a psychoanalytic viewpoint, the unpleasant emotional experience associated with such danger situations could be seen as a type of anxiety. By 1926, Freud had distinguished between two types of anxiety. In threatening situations, signal anxiety arose as a warning. As such, it always implied an outer referent. But there was also a more basic, internal, instinctual anxiety. This was the type most commonly associated with neuroses. Recognizing this distinction in a review of psychoanalytic theories of anxiety, Compton (1980) proposes that further study be given to the question, "What is the relationship between sensory perceptions associated with painful stimuli, and the sensation of disequilibrium or 'need'?"

The notion that anxiety might be of two types, as proposed by Freud and reiterated by Compton, finds similar expression in the work of Henry Murray. Murray based his formulation about personality on psychoanalytic principles (1938). He stressed that a personality theory must consider the organism and its milieu taken together. He emphasized the dynamics of the person-environment unit, and characterized the kind of effect the stimulus situation had upon the organism as an environmental tendency to press. The press could bring the threat of harm or the possibility of benefit to the organism. Murray further maintained that behavioral trends might be motivated by a drive or need within the individual.

Throughout the 1920s and 1930s research into stress proceeded along the two established lines, physiological and trauma studies. It was only after

World War II that stress began gradually to be seen in a wider psychosocial context. One impetus came from the work of another physiologist, Hans Selye.

In his book The Stress of Life (1956), Selye reported on tissue studies of endocrine glands. In these studies, he observed and measured tissue changes which he saw as stress manifestations. Relating his work to the findings of physiological research linking specific changes with stress, Selye sought a unifying stress theory. He proposed a definition of stress as a state manifested by a syndrome consisting of nonspecific induced changes within a biologic system. He saw the organism's generalized response, which he called the general adaptation syndrome, as a stress syndrome. For Selye adaptation was a key concept. Life, he maintained, was largely a process of adaptation. It was through the general adaptation syndrome that various internal organs helped man to adapt to the constant changes in his environment. Although Selye's theory was grounded in biology it was the psychosomatic and psychosocial implications of his work that later stimulated considerable interest in the area of stress.

Throughout the 1950s and 1960s stress began to be increasingly studied in a broader psychosocial context. It was, as Selye had said, an inevitable part of life. Gradually a psychosocial perspective on stress was introduced as various interactionist models were proposed (Endler, 1982). From this perspective, stress is seen as arising from the interaction between the person and his situation. Endler and Magnusson (1976) have presented four basic postulates of interactional psychology: (1) behavior is a function of a continuous and bidirectional process of person-situation interaction; (2) the individual is an interactional, active agent in this process; (3) motivational,

emotional, and cognitive variables play important determining roles on the person's side; and (4) the psychological meaning that the situation has for the person is an essential determining factor of behavior.

Other researchers later emphasized the cognitive variables that gave psychological meaning to events and situations that helped to determine the stress associated with them (Arnold, 1960). Lazarus (1976) conceptualized stress as a problem arising out of a demand that taxes the system composed of an individual and his environment. A key role is played by the cognitive appraisal of the demand by the individual. Primary cognitive appraisal is the mental process of evaluating an event in terms of its significance for one's well-being (Lazarus and Launier, 1978). A judgment is made whether the event constitutes a threat with the possibility of harm or loss as a consequence (Coyne and Lazarus, 1980).

These issues led researchers to investigate the stimulus properties that might make it stressful, and the appraisal process which could be seen as a means of mediating the stressfulness of the stimulus. Other properties of the individual and the situation that might serve as mediators of stress were also being identified and examined. There was an interest in the response to stress, the coping skills employed in adapting. Finally, there was continued interest in the effects of stress, emotional, behavioral, and physical.

As the study of stress evolved from a concern with specific traumatic events to more general psychosocial situations, physiological and psychosomatic research was also expanding. The role of stress in the etiology of various illness and disease became the subject of intensive study. The role of stress in cancer (Achtenberg, Simonton, and Simonton, 1976), ulcers (Cobb and Rose, 1973), heart disease and hypertension (Wheatley, 1981), and a

number of other physical problems, was investigated. As the debilitating effects of excessive stress became better understood, interest grew in techniques to manage and reduce stress.

One such technique employed biofeedback to help the individual gain control over aspects of autonomic functioning by providing him with ongoing information about functions like heartbeat, galvanic skin response level and muscle tension. By monitoring these functions and making conscious attempts to alter them, changes could be effected.

The introduction of biofeedback techniques renewed interest in progressive relaxation, a technique originally advocated by Jacobson in the 1930s. Jacobson (1938), noting that emotional problems were often associated with skeletal tension, reasoned that muscular relaxation might have a positive effect. He suggested that with conscious attention and practice, an individual could learn progressive relaxation.

The preceding review, although brief, results in two general impressions of the concept of stress: (1) it has a certain intuitive appeal, and (2) it is vague and overly inclusive (Apply and Trumbull, 1967). Yet it may be the very elasticity of the concept that gives it much of its intuitive appeal and utility in psychosocial applications. Lerner (1982) recognized that when he said, "a lot of fuzziness about the concept of stress is what makes it so valuable." He goes on to quote Aristotle to the effect that it is always an error to try to make a science more exacting than its subject allows for. Nevertheless, some definition is called for if subsequent activities like identification, observation, assessment and measurement are to be conducted in the scientific study of stress.

From the perspective reviewed, psychological stress may be viewed as a stimulus or as a transaction. In the former it may be defined as a state of emotional tension arising from two main conditions: failure of the environment to meet the needs of the individual, or events or situations which the individual perceives as threatening. Seen in this way stress is a stimulus (McGrath, 1970). It can act as a drive or motivator (Farber, 1955), as the individual seeking drive reduction, responds in adaptive or maladaptive ways identified as coping responses. Viewed as a transaction stress can be defined as an imbalance between perceived demands and perceived resources with negative consequences for an individual's well-being, then support will be that which serves to (1) redress the imbalance (by decreasing demands and/or by increasing resources) and/or (2) alter the consequences of failure to meet demands.

Daily Life Stresses

The study of the more ordinary life events has been traced to Adolf Meyer's (1866-1950) work at the turn of the century (Dohrenwend and Dohrenwend, 1974). Meyer was a Swiss physician who, after immigrating to America in 1890, worked in a number of state hospitals. Through his work he became convinced of the importance of collecting life history data on patients. Later, as head of the New York State Pathological Institute, he established standards and procedures for the systematic collection of data, including information on the patient's home, family, and life situation. He suggested the use of a "life chart" to facilitate data collection. Such a device would list changes of habitat, of school entrance, graduations or changes or failures; the

various jobs; the dates of important births and deaths in the family, and other fundamental important environmental influences (Lief, 1948).

Modern interest in stress-producing life events is due largely to the important contributions of Thomas Holmes and his associates begun in the 1950s (Holmes and Rahe, 1967; Holmes and Masuda, 1974; Holmes, 1979). They adopted Meyer's idea of the life chart as a means of systematically collecting data on patients that would allow a detailed examination of their lives in prospective and retrospective investigation of illness. They attempted to develop a life chart to study the quality and quantity of those events which were empirically observed to cluster near the time of the illness. This list was composed of events that have significance in American society, such as marriage, trouble with the boss, death of a spouse, and so on. They included in their list not only those that might normally be seen as negatively stressful, but also those that might be socially desirable, following a definition of stress as arising from events which disrupt equilibrium (Gramezy, 1981) and require some adjustment on the part of the individual.

Another approach, analogous to that taken by researchers with adults, was to study the role of stressful life events in predicting children's physical problems. Mutter and Schleifer (1966) examined the histories of hospitalized children by conducting a semi-structured interview with their parents in order to obtain information on life events and family interactions that occurred within the six-month period preceding the onset of somatic illness. When matched with a healthy control group, the hospitalized group showed a significantly greater number of changes in their psychosocial setting. In addition, significantly more children with somatic illness had experienced actual and/or threatened loss than had healthy children. Differences in

socioeconomic status and neighbourhood social structure were not found to be significant factors.

Children's Response to Stress

The effects of stress, particularly if it is prolonged and severe, can be pervasive. Freud's famous dictum that a problem is significant when it affects the individual's ability to love or work calls attention to two essential aspects of the human experience. For the child, work is equated with school performance, for it is in school that one's resources must be marshalled for sustained, concentrated, and goal-oriented effort. Love, in the broadest sense, encompasses the range of family and social relations, including the capacity for positive interpersonal bonds.

The adverse influence of stress on general school functioning and academic performance has been clearly demonstrated (Felner, Ginter, Boike, and Cowen, 1981; Sandler and Block 1979; Shinn, 1978; Felner, Stolberg, and Cowen, 1975).

Shinn (1978) conducted an extensive review of the literature on the detrimental effects of father absence on children's cognitive development as assessed by standardized IQ and achievement tests, and school performance. She found that in single-parent families financial hardship, high levels of anxiety, and low levels of parent-child interaction were all associated with poor school performance by children.

Felner et al. (1975) studied two types of stressful experiences found in the histories of primary grade school children: parental death and divorce. Both "crisis" groups were compared, first to demographically matched referred controls without crisis histories, and then to each other. Teachers were asked

to rate the children with reference to the amount of maladjustment they showed in school by using a screening instrument, and Teacher Referral Form. Each experimental group had a significantly higher overall maladjustment score than its comparable control group. Children with a history of parental death were significantly more anxious, depressed, and withdrawn than the matched controls; separation/divorced children had more aggressive and acting-out problems than their controls.

In a subsequent study, Felner et al. (1981) further examined the effects of parental divorce or death on the school adjustment of young children. Children with a history of these stressful life events were found to show greater overall school maladaptation than children without such histories. Children of divorce had significantly more acting-out problems, and those with histories of parental death had more shy-anxious problems than their control groups. The authors concluded that the association between specific crisis history and specific school adjustment patterns may have implications for the study of coping with stressful life events and for preventive efforts.

Sandler and Block (1979) extended the investigation of children under stress beyond the school to include the home. They asked teachers to identify maladapting children in four inner city schools. Teachers then rated the maladaptive and control children on dimensions of maladaptive behavior using the Adolescent Maladjustment screening instrument. Parents were also asked to rate their children's behavior using items from the Louisville Behavior Checklist. They then compared the children's recent life histories by using a life events schedule.

In their analysis of the data the investigators found that on one of the demographic variables, source of income (on welfare), also differentiated the

maladjusted from the control group. By dividing the maladapting group into two subgroups, those whose families were on welfare and those whose families were not, it was found that, in general, maladapting children were more likely to have been on welfare, and to have experienced significantly more stressful life events during the previous year, than the matched control group. When the maladapting group was divided into welfare and non-welfare subgroups, it was found that the non-welfare maladapting group had experienced more life events than either the non-welfare controls or the maladapting welfare children. In addition, the non-welfare maladapting group showed a high correlation of parent ratings of behavior problems with the measure of life events.

In a study that went beyond the school and family to examine the broader issue of the effects of stress on social relations, Hetherington (1972) studied the effects of father absence due to divorce or death on adolescent girls. She found disruption in their interactions with males. With daughters of divorce this behavior took the form of proximity seeking with males, early heterosexual behavior, and more open responsiveness. By contrast, the daughters of widows showed inhibition, rigidity, avoidance, and restraint around males.

The above results indicate that stress has been found to be associated with poor school performance, ineffective functioning at school and in the home, problems in social relations, and a variety of emotional reactions all of which are ultimately embedded in the coping mechanisms developed by the child.

According to Lazarus et al (1974), the two major modes of coping are problem-solving and emotion-regulating coping which, for research purposes,

Jalowiec terms as problem-oriented and affective-oriented coping methods (Jalowiec and Powers, 1981). Problem-solving modes of coping focus on rational methods directed towards changing the stressful situation or event (Lazarus et al., 1974). However, it is unlikely that problem-oriented coping methods can be studied accurately in adolescents since theory suggests that, while they have some problem-solving skills, for many, especially in early adolescence, formal logical thought processes are either not fully developed or are significantly impacted on by affective responses. (Inhelder and Piaget, 1958). Conversely, emotion-regulating modes of coping focus on primitive methods that attempt to regulate the emotional response to the stressful situation. While they are not directed at changing the objective circumstances, emotion-regulating coping methods can create an illusion of comfort and safety. Relevant to this study is the proposition that the greater the perception of stress or frustration associated with the situation, the greater the likelihood that the individual will use emotion-regulating coping (Lazarus et al., 1974).

Special Considerations of Childhood and Adolescence

In addition to the specific instances of stress associated with potentially stressful life events, there are two other major sources of stress in childhood and adolescence: normal developmental stresses, and endemic, general social stress.

Normal Developmental Stresses

Child development workers have long recognized two levels or modes of thinking, sometimes called magical and realistic. Kessler (1966) points out that this is similar to Freud's distinction between the pleasure principle

(primary process thinking) and the reality principle (secondary process thinking). Freud illustrated primary process thinking by the dream in which anything was possible, often in defiance of logic. Gradually the more realistic secondary processes begin to dominate the child's mental activity, although lapses or regressions to more primitive primary process thinking continued throughout life.

The inconsistencies in perception can be important in the etiology of emotional disorders for which many adolescents are referred for treatment. Kessler (1966) relates these inconsistencies to symptom formation:

> A symptom originates from affective needs rather than logic and it usually contains within it a kernel of irrational thinking . . . some object . . . has become invested with all kinds of extra meanings beyond the realistic or logical.

The dissonance in perception may be seen when the child or adolescent, in appraising some event or situation, perceives the threat of harm or loss. If this perception results from primitive thinking, it may well be that an observing adult would characterize the adolescent's perception as unrealistic. Nevertheless, the adolescent adopts a stress response in an effort to cope with the perceived stress.

The normal course of human development involves change, and change is often stressful. Erikson (1964, 1968) in his theory of development, sees the process as a series of potential crises. A crisis is a time of increased vulnerability to a particular psychosocial problem. Successful resolution of these crises fosters development and contributes to the healthy, growing

personality. Erikson describes five developmental crises during childhood and adolescence.

The first crisis occurs in infancy, and is labelled as *trust versus mistrust*. It may be that the infant's first experience of stress occurs when physical needs are not met immediately. Crying does not bring an immediate response from mother. The tension that arises as a result of that delay serves as a prototype for later stress arising from unmet needs. A basic trust of the environment (and significant others) can develop if needs are reasonably met. Feeding, touching, loving, caring, and attending to the child's needs foster the sense of trust.

The second crisis is what Erikson has called *autonomy versus shame and doubt*. This occurs in early childhood, as the child begins to test his control over his environment. At this stage the toddler has the first opportunity to exert some independence. As the child ventures forth to explore, there is the inevitable separation from the mother. If stress is associated with this initial attempt at separation, it is likely that later life events that involve separation, like going to school, leaving home, and marriage, will be highly stressful for the individual. If the child is not allowed to achieve some degree of separation, a sense of shame and doubt in one's capabilities could result. On the other hand, if the child is able to achieve some initial emancipation from the mother, a sense of autonomy may be gained.

The crisis of *initiative versus guilt* occurs at around four to five years of age. Initiative results from a developing sense of purpose, curiosity, and ambition. The parents may deny the child permission to explore certain places or to engage in some activities. Their prohibitions are important in forming

the child's conscience. Unusually restrictive adults may block initiative, frustrate and inhibit the child, and engender a sense of guilt.

The crisis of *accomplishment versus inferiority* provides a theme for much of the child's school years (ages six through eleven years). Intellectual curiosity and performance dominate the child who learns by doing. Since the sense of accomplishment is so intimately bound with the emerging self-image, disruptions in learning can have damaging effects by engendering feelings of inadequacy and inferiority. Accordingly, learning difficulties in school are a major source of stress at this age.

Learning requires certain preconditions and readiness on the part of the learner. For a child, readiness involves a degree of development in physical, psychoneurological, language, and cognitive skills. A developmental lag in any of these readiness skills can become a major source of stress.

For many children school provides the first opportunity to match their skills against peers from outside of the family. The school represents the outside world, which is capable of evaluating one's inadequacy. To borrow a phrase from Goffman (1959), the school experience might be seen as "a presentation of the self". The developing child is unsure of his or her identity, the new set of expectations, and his ability to measure up in the eyes of teachers, peers, and of course parents. The competency they can demonstrate to others and to themselves through academic mastery helps to build a sense of adequacy. Similarly, problems in learning can lead to feelings of inadequacy and self-doubt. Parents, teachers, and other significant adults hold expectations of the child's performance. Self-doubt and a sense of inadequacy arise when children see themselves as failing to live up to those expectations. Academic competency easily becomes equated with self-competency. The

child's perceptions of the learning situation, of the expectations of parents and teachers, and of his own performance are potential sources of perceived stress.

The last major crisis to be considered here is that which develops during adolescence. Erikson called it *identity versus confusion*. Adolescence has long been seen as a period of storm and stress. The rapid changes associated with it place the individual in a highly ambiguous position between childhood and adulthood. Sexual needs become stronger. Peer relations take on a new dimension, and a growing need for independence provides a new set of demands. Ambiguity, uncertainty, and doubt lead to an intense questioning and exploration of new roles. The adolescent who is able to succeed in integrating changing roles, having his or her needs met, and coping with new demands will emerge with some understanding of himself, a self-identity.

The adolescent crisis is not a single, discrete event. Rather, it may be seen as a series of related stress situations involving personal, sexual, social, and occupational concerns.

Personal growth, at this age, involves establishing self-image consistency. This inner consistency brings definition to the adolescent as a person in his own right. It serves as the bridge between discarded childhood and future adult status. But the consistency of beliefs, attitudes, behaviors, values and style which will make the self-image does not come easily. In order to develop a consistency that will serve over time and across situations, the adolescent tries out various roles. This experimenting is unpredictable and erratic, sometimes prolonged, and almost always stressful. It is fraught with difficulties. It calls into question one's acceptance by the family, and, very importantly, by peers. It is often seen as a rebellion against dominant values, although the alternatives may be vague or unrealistic. Values that can provide

comfort and give meaning to existence are cast off; the effect is to leave the adolescent adrift. If the adolescent sees his tentative self as being threatened by parental efforts to keep him in a childhood role, a renewed effort to carve out some area of independence is likely. Rebelliousness may be seen as a way of coping with the stress of the situation by attacking the perceived aggressor.

In times of inner doubt and uncertainty one may turn to others for confirmation. Because self-doubt and uncertainty are so chronic in adolescence, the need for others to approve is particularly strong. The group of adolescents thus becomes a mutually reinforcing circle, defined by social mannerisms that support group identity. There is a strong devotion to the tastes, interests, clothes, music and language of the group. Popularity and acceptance become important goals, and exclusion and rejection the painful consequences of failure.

Group membership always requires some sacrifice of individuality. Assuring a place in the group may mean violating some norm, personal, parental, or legal. This creates another set of problems, since it requires submerging one's individual identity in the interests of group membership. since the adolescent depends on group membership to assist in his developing identity, the potential for stress is very great.

Even under the best of circumstances, adolescence is stressful. It provides a graphic example of developmentally induced stress. The stresses of childhood and adolescence are an inevitable part of development, and they are necessary for growth. If they are prolonged and/or unusually severe, however, they can have damaging effects. If the various developmental stages are not negotiated in a healthy way then adolescent functioning is often characterized by impaired functioning and serious psychopathology results.

Endemic Social Stress and its Effects on Children

Unlike the specific instances of stress associated with discrete events and situations, there is a more general psychosocial stress endemic to society. In contemporary Western societies, the rapid social and technological changes of the past few decades have increasingly strained the capacity of individuals to adapt.

Children, like their parents, have had to cope with these social trends and the rapid changes they have produced. While the implications of social change are beyond the scope of this thesis, one example might prove useful in identifying how social change has affected parents and their children.

One major trend that emerged during the 1960s was embodied in the human potential movement. While the movement advocated the development of each human being's unique potential, it also provided a rationalization for selfishness. It fostered the myth that any number of potentials could be actualized in a process of growth without pain or sacrifice. However, when individuals sought to have all their needs met, they often found it was at the expense of family and social responsibilities.

The rise in divorce rates, alternative living arrangements, and the general erosion of the family were some of the obvious changes encouraged by this trend. One important implication was found in the effect this trend had on parents' attitudes toward children.

In even the best of circumstances there is a natural ambivalence toward children. They require sacrifice, particularly on the mother's part, the postponing of personal goals and interests, restrictions on personal freedom and enjoyment, and economic burdens. Luckily, there are strong innate tendencies toward love and the protection of the young that counterbalance

these feelings, so that children are assured a reasonable measure of parental love and acceptance.

However, when social trends exacerbate these ambivalent feelings, parents may be driven to increasingly extreme methods of coping. One extreme response may be found in instances when parents, in order to meet their own needs, foster a pseudo-maturity in children, often under the guise of encouraging independence. The children of those parents are essentially deprived of their childhood. Not allowed to be children, they are forced to try to cope with an adult reality for which they are not emotionally prepared.

Another example of an extreme response may be found in instances when parents are tentative about accepting the responsibilities of parenthood. While occasionally they may openly abdicate that responsibility, it is more likely that they may hold back from a total commitment. The result is some withholding of love, or alternatively a giving and withholding, in an inconsistent pattern. The children of such parents react to what they perceive as a deprivation of parental love and they, in turn, may also adopt extreme behavior patterns in their efforts to cope with the resulting stress, confusion, and insecurity.

Anthony (1978) has pointed to the potentially disastrous consequences of this social trend:

> The growing disinterest in child rearing among young adults in our society and the trend toward postponement of having children is increasingly evident. Not only are fewer children being produced in almost all the developed countries, but these are turned over to the care of others while parents go out to work. Some have seen this as questioning the existence of an innate drive toward parenthood . . . but it may well be that social and cultural factors have a much greater impact on out innate behavior than we hitherto realized. It may even be that

> in our child-rearing methods we are raising children who no longer care to raise children. I would thus agree with Rexford that one of the major risks to children of this century in the Western world . . . is the ambivalence of adults. This is a large psychological hammer hanging over the heads of children . . . (p. 13).

Mediators of Stress in Children

While earlier studies tended to examine the relationship between stress as a noxious stimulus and some disease or discomfort as a response, the limitations of this simplistic one to one relationship became increasingly apparent (Coyne & Lazarus, 1980; Jenkins, 1979). It was obvious that there were individual differences that might account for the fact that two individuals, exposed to identical stressful stimuli, might respond in widely divergent manners. This led to the investigation of individual differences in stress research and coping mechanisms. Dohrenwend (1974) put it this way:

> A major question, and for some investigators the central problem concerning the effects of stressful life events, grows out of the observation that one individual may become ill and another remain healthy after both experience the same life event. The most general formulation of the research question generated by these individual differences is: What are that factors that mediate the impact of stressful life events on the individual? (p. 316).

Specific stressful life events of children and adolescents offer opportunities to observe the effects of stress and to gain some understanding of the factors that serve to influence those effects. Adolescents in therapy offer a unique opportunity to study family dynamics.

The Role of Parents

Because of the generally recognized crucial role that parents play in interpreting life events for their children, providing models and giving them emotional support, their individual personalities, as well as their relations to each other and to their children, they are important agents in the patterns of coping the latter develop. Moore (1975) calls parental adjustment a key factor in the production of well-adjusted children. He cites evidence of problems of children resulting from situations in which a parent was diagnosed as mentally ill. Studies have also found a relationship between parental, particularly maternal, mood (such as depression and hostility) and adjustment problems in children (Shearman, 1968). Other studies have shown that maternal satisfaction is important to the child's development (Yarrow, 1962).

In comparing stressed mothers who had mistreated their children with a similar group who had not, Egeland et al. (1980) found personality differences. Stressed mothers who mistreated their children were found to have higher scores on aggression and anxiety, and lower scores on succorance.

Some idea of the role of parents as mediators can be seen by the analysis of traumatic events (Sibler et al. 1957). In their analysis of parent-child interaction when a tornado struck the town of Vicksburg, Mississippi, - communication between parent and child at the time of impact, and in the aftermath of the disaster was investigated. They concluded that one essential role involved influencing the child's integration of the experience. Supportive parents were those who were aware of their child's need to temporarily regress during the stressful situation. In addition to being accepting of the child's behavior they sought to return the child to previous levels of functioning as soon as reasonable.

While no one pattern of child handling seemed better in all cases, the authors felt that whatever pattern was chosen, it would be more successful if it was characterized by consistency. They concluded that

> Granting the merits of the facilitation of communication, the maintenance of parental roles, and the acceptance of regressive and symptomatic behavior, we felt that, if there was any parental behavior making for a better adjustment in the child, it was probably consistency and lack of confusion (Silber et al., p. 165).

The Impact of Significant Life Events on Psychological Functioning

While some correlation has been found between significant life events and certain psychological problems, the question of causality remains unanswered.

While ordinary life events might be expected to affect children's functioning, the subject was probably first investigated because of the belief that childhood experiences have a considerable impact on later development. Brown's (1979) findings that the loss of a mother before age 11 acts as a vulnerability factor to increase the risk of depression is typical of that reasoning. Langer and Michael (1963) maintain that no single stress or combination of stresses is so great a statistical risk to adult mental health as an accumulation of stressful factors in childhood, the risk being directly proportional to the number of such factors.

A longitudinal study by Moore and his colleagues (Moore, Hindley, and Falkner, 1954; Moore, 1959) at the Centre for Human Development in England followed a group of subjects from before birth to adolescence. They investigated the consequences of such potentially stressful experiences as temporary separations of various kinds, the birth of a sibling, change of home,

divided daily care, and others. In addition, they examined certain conditions at and before birth, which might help to determine the individual's reactions to such experiences.

In the course of their investigations researchers (Coddington, 1972; Heisel, Raitz, Ream, Rapport, and Coddington, 1973) developed lists of stressful life events for use with children and adolescents. Following Holmes' procedures, Coddington calculated life change units for each stressful life event. He compiled lists for the various school age groups and discovered that life change scores increased with age, while there was no significant effect due to race or social class on scores.

As some consensus developed on what were significant stressful life events of children, the effects of these events on children's mental health became new avenues of research (Gersten, Langer, Eisenberg, and Orzeck, 1974) and on school performance and classroom behavior (Boike, Gesten, Cowen, Felner, and Francis, 1978). For example, Felner, Stollberg, and Cowen (1975) found that 20 percent of the children identified by teachers as having adjustment problems had a history that included either divorce/separation or death of a parent.

While the study of life events as stressors necessitates some identification of, and agreement on, those events which may be potentially stressful, the perception which the individual holds of various events remains crucial in determining whether a given event will be stressful for that individual. Haan (1982) addressed this point when she stated that no listing of objective stress stimuli was likely to be satisfactory because "stress is the result of a situation having a certain meaning" (p. 256).

Researchers have consistently emphasized the key role of perception. Endler (1975), for example, sees the perception of situational interpersonal threat as determining the extent of anxiety in a given situation. Lazarus (1981) has also emphasized the central role of cognitive appraisal in threat, loss, or harm situations.

Magnusson (1982), in discussing the situational aspects of stress, distinguishes between the *actual* environment and the *perceived* environment. He sees early stress research, strongly influenced by behaviorism, as concerned with the actual environment. He goes on to point out that the research on life events and their stressful effects has been strongly affected by theories dealing with moderating effects of perceived social supports, perceived prediction and control, etc (Sarason and Sarason, 1981). As Magnusson (1982) explains:

> This (perceived environmental) approach has been particularly important in interactional personality theory. And this view has greatly influenced research in stress and anxiety. It has changed the focus from an interest in how external stimulation per se provokes emotional, psychological, and behavioural anxiety reactions to an interest in how stress reactions are elicited by expectations about the consequences of stressful conditions (p. 232).

The effects of family dysfunction on children and adolescents may be physical, psychological, and/or behavioural. The psychological and behavioural effects of the stressful situations associated with divorce, death of a parent, and other specific life events offer opportunities to observe the effects of these events, and to gain some understanding of the factors that serve to influence those effects.

Dysfunction in Children and Adolescents Caused by Parental Loss

The loss of a loved one is always a painful experience. The nature and severity of the effects on the child who has lost a parent through death will vary depending on a number of mediating factors.

The most common reaction seems to include initial incidents of acting out or conduct disorders, usually following, or within a few months of, the loss (Epstein, Weitz, Roback, and McKee, 1975). This initial reaction is followed by lowered self-esteem, guilt and depression (Grossberg and Crandell, 1978). Other behavior disorders have been associated with parental loss such as depressive and phobic disorders, and school refusal (Arthur and Kemme, 1964). Some maintain that the effects may not be seen for months or even years. Rutter (1966), for example, found that in his clinic sample there was a gap of five years or more between parental death and the onset of symptoms in the child.

In general, the studies have shown that loss of a parent by death may precipitate impaired emotional development and/or psychopathology (Epstein et al., 1975; Shepherd & Barraclough, 1976). For example, Kirkpatrick, Samuels, Jones and Zweibelson (1965) found that children who experienced the loss of a parent through death showed reduced academic achievement, more physical illness and psychological adjustment reactions. Lifschitz (1976) reported that bereaved children displayed greater oppositional behavior, restlessness, and restriction of general cognitive level when compared to a matched control group.

Age has been shown to be an important factor influencing the child's capacity to cope, as have the sex and ordinal position of the child. Children most at risk are those who have lost a parent during the ages of three to five

years, or in early adolescence (Black, 1978). Being the oldest sibling seems to increase the risk of maladjustment, while having an older sibling of the same sex as the deceased parent apparently protects against subsequent disorder (Birtchness, 1971). Still another important mediating factor concerns the support provided by the surviving parent. The surviving parent's response, efforts to cope, availability, and the support he or she can provide in this stressful situation have been found to be of considerable importance in mitigating the impact of the loss (Pattison, 1976; Silverman and Silverman, 1979). It follows, therefore, that family dysfunction would be a negative force in the child's efforts to cope with loss of a parent.

Divorce of Parents and its Effects on Children and Adolescents

Divorce causes considerable disruption in the life of the child, even in those situations where the parents may separate on more or less amicable terms. Family moves and relocations, changes in financial support, different child-care arrangements, and possibly a change of school and friends may all accompany the divorce and are additional factors which impact on the child's coping skills.

The effects of divorce are influenced by a number of mediators including the psychological characteristics of the child, parental attitudes and behavior, family functioning and social supports. In addition, important differences have been found between the sexes and among various age groups.

The impact of divorce has been found to be more pervasive and enduring for boys than for girls. They show a higher rate of behavior disorders and problems in interpersonal relations in the home and in school with

teachers and peers. Both boys and girls also show increases in dependent and attention-seeking behavior (Hetherington, 1979).

The differential effects at various ages are more difficult to conceptualize. Kalter and Rembar (1981), in seeking to understand the significance of the child's age on the effects of divorce, have proposed three viewpoints often found in the literature. First, the cumulative effects hypothesis holds that the earlier the divorce occurs in the life of the child, the greater the psychological impact will be. Second, the critical stage hypothesis suggests that at certain times the child's development may be more vulnerable to the particular problems caused by divorce. For example, during the Oedipal phase the absence of an appropriate figure for same sex identification may have greater significance. Third, there is the recency hypotheses which holds that most reactions are likely to occur immediately following the divorce, with little or no long term effects.

Hetherington (1979) believes that most children can cope with and adapt to the short-term crisis of divorce within a few years; however, if the stress situation is prolonged, developmental disruptions may occur. Moreover, she sees important developmental differences between young children and adolescents. The young child has a tendency to blame himself in interpreting the divorce. He is also more likely to hold distorted perceptions of the parent's behavior, and to equate the separation with total abandonment (Tessman, 1978; Wallerstein and Kelly, 1974; 1975). While most adolescents will experience initial pain and anger when their parents divorce, when the immediate crisis is over they are more able to assign responsibility for the divorce, and to cope with other practical exigencies (Wallerstein and Kelly, 1974, 1975).

In a major nationwide study designed to assess the impact of parental divorce, Guidubaldi, Cleminshaw, Perry, and McLoughlin (1983), reported on over 300 children from divorced families in school, and a number of randomly selected controls from intact families. When examining differences between children from divorced and intact families, these investigators found that important differences emerged in both social-emotional and academic-intellectual criteria. Intact family children showed better classroom behavior, were absent less frequently, showed higher peer popularity, demonstrated more internal locus of control, and had higher full scale IQ, reading and spelling achievement scores. They also found that divorced-family children were far more likely to have been previously referred to a school psychologist, to be in programs for reading difficulties, and to have repeated a grade in school.

By examining the differences within the divorced- family group, the authors were able to comment on the influence of sex and age as mediators. One of the most powerfully demonstrated findings was that in divorced-family households, girls were consistently better adjusted than boys. They were also less likely to have repeated a grade in school. Somewhat surprisingly, the authors found that first graders showed far fewer adverse effects that fifth graders. In general, the younger children seemed to show better adjustment than the older children.

Finally, the investigators found that characteristics of both the home and school environments could help to reduce the detrimental effects of divorce.

It is worth remembering that while divorce is always a painful experience, there are times when it is the best solution to a destructive family

relationship, and it is by no means inevitable that children will show extreme responses. There is a wide variability in its effects on children. Hetherington (1979) addresses that issue when he writes:

> . . . investigators are beginning to examine the interplay among situational factors, stresses, and support systems. However, even when these factors are comparable, wide variability in the quality and intensity of responses and the adaptation of children to divorce remains. Some children exhibit severe or sustained disruptions in development, others seem to sail through a turbulent divorce and stressful aftermath and emerge as competent, well-functioning individuals (p. 852).

Summary

From the foregoing review it will be recalled that in assessing the response of individuals and/or systems (families) to stress, Caplan (1981) compares different analyses of the sequence in which various supports are appropriate. He suggests that there are four "phases of response" to stress, in each of which a coping function takes place. The first two phases consist of problem-solving in which the tasks are to reduce the threat or escape it, to change the environment or to enable the individual to leave it, and/or to assist the individual in acquiring new capabilities to change external circumstances. The third and fourth phases are emotion-focused and involve intrapsychic efforts to come to terms with the stressful event and its sequelae. He also suggests that help given out of sequence will not be effective.

Weiss (1976) delineates a model of stress in which deleterious responses can be positively mediated by a sequencing of support ie: emotional, cognitive, and material, or, in Caplan's terms, first pallation and then problem solving. Weiss (1976) and Caplan (1981), then, present

apparently contrasting models of the effect the timing of support can have in stressful situations. The question that needs to be addressed however, is whether these different interpretations are related to different emperical situations. Pearlin (1985) notes that "each stressful situation for which supports are mobilized may have its own natural history" (pg. 48). By studying the ways in which individuals and/or systems mobilize and utilize supports in relation to different experiences perceived as stressful, it should be possible to deal with this issue.

The second factor impinging on the response of individuals and/or systems to stressful situations is the timing of support which is related to transitional learning. This refers to the rates at which people learn new assumptive worlds in response to different types of stressful situations. For example it seems that the integrating of stepfamilies is a process which may be completed by four years, but which in many instances extends well beyond that time (Papernow, 1984).

From a contextual analysis both the appraisal of events as stressful and the evaluation of behaviour as supportive are influenced by the context in which they occur (Cohen and Syme 1985; Pearlin 1985) including the contexts of situation, time, personal characteristics, social structure and culture. In this study the situational context is examined by analysing the relationship between type of stressful situation or stressor and type of familial support; and (b) the personal context from the perspective of personal dispositions (in this study, diagnosed personality factors) as they impinge on and influence the individual's and/or system's (family's) response to stress.

B. Review of the Literature on Dropouts

A review of the nature and extent of patient dropout from brief and long-term psychotherapy highlights a number of factors that need to be considered when undertaking research in this area, some of these are discussed in this section.

The problem of patient dropping out of treatment has received detailed consideration from a number of authors (Bakeland & Lundwall, 1975; Blackwell, 1976; Eiduson, 1968; Rosenberg & Raynes, 1976). However, as earlier indicated, the ability to make comparisons has been seriously limited by marked inconsistencies. For example, a patient was considered a "dropout" in some studies on the basis of a particular number of sessions, and in others on the basis of a number of weeks or months in treatment. Further, when calculating results, many authors did not distinguish among patients who were referred, patients who were offered treatment, and those individuals who actually began therapy. The definition of 'termination' was similarly obscure; it was seldom specified whether the treatment ended at the initiative of the patient or therapists, or whether it was determined by mutual agreement.

The multiple factors that account for the wide range in reported patient dropout rates from different treatment methods are discussed under the following category headings that are considered relevant to the present study: selection of the patient, specificity of the treatment, setting of the treatment, and the client-therapist relationship.

Selection of the Patient

Dropout rates have been shown to be lower for patients in brief psychotherapy than for those in long- term psychotherapy. This indicates a relationship between specificity of treatment and the process of selecting patients for that treatment. As Tyson and Sandler (1971) emphasized, the treatment should be selected for the patient. The selection process, therefore, requires an appraisal of the aims, techniques, and parameters of any particular treatment as they might be suited to the needs, expectations, motivations, and capacities of the patient. Levinson (1962) pointed out that, in addition, patients also participate in the selection process. He suggested that during the initial assessment period, a patient is determining for himself whether or not the programme is able to offer him what he seeks.

Assessment and Acceptance

Varying degrees of selectivity or acceptance by programs with different screening procedures has been thought to account for the wide differences in these programs' "holding power" (Gallagher & Kanter, 1961; Rogers, 1960). Lief et al. (1961) compared the low dropout rate in their Tulane University clinic with the higher rate reported by Rosenthal and Frank (1958) from the Phipps Clinic in Baltimore. Lief et al., who used a single, experienced assessor in patient selection, concluded that the Phipps Clinic's practice of having a number of psychiatrists making decisions on patient selection accounted for the increased dropout rate reported from Baltimore. However, some patients in the Tulane study were seen as often as four times weekly, which may have been responsible for the different dropout rates rather than the specific selection procedures.

Selection Criteria

Discussions of selection criteria for differing forms of psychotherapy appear remarkably similar. Most authors considered intelligence, psychological mindedness, motivation, "ego strength," capacity for sustained relationships, the nature and pattern of defenses, and the current life situation of the patient to be particularly important areas to evaluate for all forms of psychotherapy.

Current opinions vary as to whether brief psychotherapy should be reserved for patients with symptoms of acute and recent onset, or whether it is suitable for patients with long-standing psychopathology. Symptoms are deemphasized by the formulation that patients with relatively less severe disturbances of personality and life situation are more suitable (Semrad et al. 1966; Stewart, 1972). Harris et al. (1963) presented yet another view, stressing the need to focus on the precipitating factors in the patient's disturbance, regardless of the underlying personality.

Specificity of Treatment

Problems of Definition

Most reports on the results of psychotherapy suffered from inadequate definitions of the forms of treatment employed. In addition, the underlying principles were not often made explicit enough to distinguish among the various forms of psychotherapy e.g., short-term or long-term psychotherapy, crisis intervention. Wallerstein (1966, 1969) pointed out that there is an unresolved debate as to whether the varieties of psychotherapeutic treatment are best regarded as part of a spectrum or whether they are separate and

distinct methods that merely share the same theoretical principles. For research, however, it is important to identify the aims, the techniques, and the parameters of a particular therapy and to define their interrelationships.

In the literature, the concept of long-term psychotherapy suffered from greater lack of specificity than did the concepts of brief psychotherapy. This researcher therefore suggests the following operational definitions, which have been employed in the Adult Outpatient Department of the Paddington Centre for Psychotherapy in London, to distinguish between emergency (crisis) psychotherapy, brief psychotherapy, and long-term psychotherapy. Emergency psychotherapy is an intervention that is aimed at resolving a crisis situation and uses psychodynamic understanding, but it is limited to a very few sessions. In contrast, brief psychotherapy aims at assisting the patient toward the resolution of a particular current conflict; treatment may have an explicit or implicit time limit. Brief psychotherapy lasts sufficiently long for an emotional relationship between patient and therapist to develop, although this treatment goal is not a primary one; neither is it necessary for the success of treatment that this relationship progress to the level of a "transference neurosis". Lastly, long-term psychotherapy also aims at symptom relief, but it enables the patient to seek a broader scope of change in personality and work toward increased personal understanding, insight, and autonomy. This form of psychotherapy involves a more thorough exploration and understanding of the historical origins of the emotional conflicts underlying the patient's disturbances, and the techniques employed include the interpretation of the current here-and-now resistances, defenses, and transferences that are relevant to the achievement of the treatment goals.

Time and Technique

Some authors have suggested different time limits for short-term psychotherapy; for example, McGuire (1965) mentioned ten to twenty sessions, and Mann (1973) twelve sessions. Stewart (1972) and Sifneos (1967) used time in treatment rather than number of sessions as their criterion, six months and up to one year, respectively. Ursano and Dressler (1974), however, stressed that it is the focal technique of brief psychotherapy that distinguishes it from the relatively nonfocal technique of long-term psychotherapy, implying that treatment length or number of sessions should be considered secondary factors.

Frequency of Sessions

With regard to dropout rate, Riess and Brandt (1965) found that patients having two or more sessions per week remained longer in psychotherapy than did patients seen once a week; they concluded that the more "intensive" the therapy, the less was premature termination likely. Lorr et al (1962) found no association between frequency of session occurring up to a maximum of twice weekly and dropping out of treatment; however they conjectured that their results might have been different at a frequency of more than twice a week. Of course, the effect of sessional frequency on outcome and dropout is related to its effect on the treatment ("working") alliance (Sandler et al. 1973) and on motivation.

Termination and Dropout

Factors relating to termination were often obscure in many studies of long-term psychotherapy. In contrast to crisis intervention or brief

psychotherapy in which termination prior to any prearranged time was often looked upon as a successful result, the "long-term psychotherapist" took a contrary view, even if the patient thought he was better within a few months. Cappon (1964) referred to "diminishing returns" after a certain period in long-term psychotherapy. Reviewing the literature on the subject, Meltzoff and Kornreich (1970) concluded that psychotherapy reaches its maximum benefit "past some undefined point" (p. 346) of time. Hollender (1964) described what might be understood as a systematic error - the therapists believe that treatment has begun, the patient soon drops out. He remarked that these patients pose only "a pseudoproblem because many of the persons seen at the clinics never actually enter therapy; it only seems as though they do" (p. 369). Hollender further suggested that some patients might "leave by mutual agreement following an evaluation which helped to clarify the nature of the situation" (p. 369).

Setting of Treatment

Under this heading the writer has grouped those factors that are considered important in assessing patients for psychotherapy.

Patient selection is affected by available treatment facilities. For example, the welfare of patients who have borderline disturbances, of those who engage in criminal acting out, or of individuals who are prone to rapid, easy regression and psychotic states is best served in a setting that can provide the proper backup resources.

Some patients do better in a setting that, to their minds at least, carries no stigmata associated with mental illness. They may more easily attend a

clinic that is in a separate building, that is not associated in any way with a hospital, and that has some relatively innocuous name.

Another relevant factor is that the theoretical and technical orientation of respective centres may affect diagnostic categories of patients treated as well as the therapeutic techniques employed. Interestingly, Meltzoff and Kornreich (1970) concluded that there is no evidence of any greater success achieved by one or another school of psychotherapy.

Client-Therapist Relationship

Ideally, a patient or family will be seen by a therapist or therapists (in a co-therapy) who can effectively carry out the specific treatment indicated by the nature of the patient(s) disturbance. A number of factors are involved in effective matching. Mechl (1965) pessimistically argued that the joint probability of a suitable patient getting a suitable therapist is around .06, reflecting the large number of these variables, few of which have been studied and controlled. Lubvisky et al. (1971) surveyed the problem of "matching". They concluded that a better treatment outcome resulted when the "number of similarities" existing between therapist and patient provided a significantly positive contribution to the relationship between them, particularly when the therapist's and patient's expectations of treatment coincided.

Meltzoff and Kornreich (1970), after reviewing a number of studies, concluded that there is no evidence to support the view that any particular personality type of therapist is more suited to treat a particular kind of emotional disturbance. However, Auld and White (1959) noted that one important variable affecting the therapist's suitability is his or her own personal experience; they suggested that therapists who have had treatment

themselves are more capable of identifying and dealing with patients' resistances. Strupp (1973) stated that psychotherapists with personal experience of therapy tend to use a more "active" technique. It may be that greater experience in treatment, including a personal experience of it, enables the therapist in addition to other benefits, to avoid the extremes of "passivity" (Roskin & Rabiner, 1976) or "activity". The treatment alliance can only benefit, particularly in the early stages of treatment when dropout is most likely.

Another important variable is the therapist's clinical experience; treatment stands a lower chance of success if the patient is the therapist's first psychotherapy case. Tyson & Reder, 1979, reported a significant correlation between inexperienced trainees and high dropout rates. Despite efforts to take into account the anticipated difficulty of the treatment and the therapists level of experience, eight out of thirteen patients (61.5%) dropped out of treatment with inexperienced trainees within the first six months, and ten patients (76.9%) within the first nine months. Of those patients in treatment with more experienced therapists, nine out of thirty-four (25.6%) dropped out within the first six months, and ten patients (29.7%) within the first nine months. Other authors report similar findings: Knapp et al. (1960) and Lazar (1976) found that psychoanalytic candidates had poorer results with their first than with their second and subsequent cases. McNair et al. (1963) found that psychotherapists with more than four years experience lost patients early in treatment significantly less often than did psychotherapists who were newer to the field. Reports by Baum et al. (1966), Dodd (1970), Hiler (1958), Katz et al. (1958) and Myers and Auld (1955) demonstrated that a psychotherapist's increasing experience enabled the patient to remain longer in treatment.

Malan (1973), illustrating the difficulties in comparing figures between treatment centres, reported that psychotherapy trainees at the Tavistock Clinic did universally badly with their first case, while trainees at the Cassel Hospital showed universal success with their first case. Although Malan stated he could find no explanation for this wide divergence, he did not indicate how comparable the settings were with regard to such things as selection criteria, the frequency at which patients were seen, or whether or not some or any of these patients were hospitalized.

Another dimension is the difference the patient perceives between the consultant (psychologist, psychiatrist, etc.) who often makes the initial assessment and the psychotherapist he subsequently sees in treatment. It frequently happens that a patient is first seen by a senior, experienced person whose attitude is warmly understanding and supportive. The patient, who feels quite disappointed to discover that he will not be working with this person, is often confronted with a younger, possibly less skillful, less understanding, less experienced therapist who may ask him to repeat everything he has already told the assessor. The disappointment thus engendered in many patients might influence them to become "dropouts" in the early stages.

In the foregoing, an attempt was made to discuss briefly some factors that might contribute to differences in dropout rates. These factors, which are external to the patient, were often insufficiently distinguished from internal factors such as severity of psychopathology, problems in motivation, and resistance. Thus differences in reported dropout rates may reflect differences in the appropraiteness of the particular modalities of treatment employed, widely varying selection procedures, differences in one or another aspect of

the treatment setting and a broad range of experience and skill of the therapists themselves.

Dropout and Dysfunction

This researcher has been particularly interested in the predictive power of familial dysfunction, as emotional and behaviour problems of adolescents have been consistently identified to be highly correlated with the degree of dysfunction exhibited by the family.

In an attempt to contribute to an understanding of the termination of adolescents from treatment, the relationship of this phenomenon to the adolescent's psychological adjustment and family functioning was examined. A multimethod approach utilizing measures of psychological adjustment of the adolescent, measures of family dysfunction, and stressful episodes during the course of treatment, was adopted. Chapter III delineates a comprehensive discussion of the research focus and method used in this research project.

III. RESEARCH METHOD AND PROCEDURES

To clarify the purpose and perspective which determined the approach adopted in this study, some general characteristics and issues relevant to the framework are presented.

A. The Program

The study was conducted at a Day Treatment Program for children and adolescents in Alberta. Clinical services at the program are divided into five subspeciality programs - a Preschool Program, a Children's Program, an Adolescent Day Program, an Adolescent Evening Program, and a Family Therapy Program. Servicing all these Programs is a Diagnostic Unit which processes all intakes to assess the suitability or otherwise of referrals. In addition to making recommendations for treatment to one of the five subspeciality programs, referrals not covered by the facility are provided with information about possible alternative services in the community.

Subjects for the study were selected from the Adolescent Day Program which offers group therapy for teenagers ranging from thirteen to eighteen years, who, for many reasons have become dysfunctional in their normal school and/or family environments.

Referral sources to the program include parents, teachers, guidance counsellors, psychologists, social workers, family physicians and psychiatrists. The program offers a relatively short-term placement averaging six months. During this period it is hoped that the adolescent will be able to recover from the personal breakdown or disintegration that often accompanies the breakdown of their school placement. In the program, the difficulties of

coping in a large school are no longer present and the adolescent can begin to sort out his or her problem in small supportive therapy and classroom groups.

The adolescent is allowed to work in the program and recover from this first stage of breakdown, and for a therapeutic reintegration process to occur before he or she is referred on to a long-term placement. This placement may be back into the normal school system or into special education of some kind, this is determined by the specific need of each adolescent.

The adolescents are divided into small groups for therapy or classroom work. Therapy groups are run by two therapy staff; the idea of having two therapy staff to each group is intrinsic to the program. Each pair provides a model of a parental couple, irrespective of their particular sex, a model of a couple working together, using individual differences and characteristics in partnership for the benefit of the adolescent. As well as acting as model, the couple are supportive of each other; when absorbing the projections of a very disturbed adolescent it is essential to be able to catch the eye of a partner who is not being overwhelmed by these projections. The therapist can thus manage to stay emotionally with the adolescent and contain the projections without being tempted to fling them back at the child.

Classroom time is provided to maintain and upgrade academic functioning in basic subjects; in addition, community input and organized outings provide elements designed to give the adolescent a wholistic treatment environment.

The ambience of the program is psychodynamically informed, at its simplest this means that all the staff have a knowledge that the unconscious exists; that disturbed adolescents are in the grip of unresolved unconscious conflicts, and that the way to help them lies in providing a contained,

understanding structure, with clear boundaries, where they can express these conflicts and work them through.

This working through can be at two levels, one where the conflict remains unconscious but is responded to appropriately; and secondly where connections are made directly and indirectly for the adolescent so that the unconscious becomes to differing degrees conscious.

Family therapy sessions for the adolescent and his or her family are held on an ongoing basis, and for those adolescents who are temporarily or permanently living outside the home family sessions are held with the caretakers.

The Intake Process

Before acceptance to the program, a rigorous diagnostic procedure is offered to each adolescent by specially trained staff in the Diagnostic Unit. The adolescent and his family are seen separately and as a unit over a period of approximately two weeks. Assessment procedures include the administration of structured questionnaires, standardized psychological and educational tests and a psychiatric evaluation. This diagnostic evaluation serves to assess the suitability of the child for the program and vice versa. It also serves as a consultation by an experienced team in formulating the nature of often elusive problems, and making referrals to treatment teams at the program or suggesting other more suitable facilities in the community.

Outcome Criteria of the Program

Patients are identified as *dropouts* based on the circumstances under which termination occurs. Some patients, subsequent to the institution of therapy, are identified as unable to continue benefiting from group therapy due to the need for specialized treatment/intervention (eg. involvement with drugs, psychotic break, etc.). Others terminate therapy due to relocation of parents, change in custodial parent necessitating physical move etc. Such terminations are not classified as *dropouts* since there is mutual agreement between parents and therapists that the termination was unavoidable.

Dropouts are those patients and their families who : (a) terminate treatment due to continued non-compliance with conditions for treatment mutually agreed on prior to the institution of therapy; (b) unilaterally terminate treatment prior to patient satisfactorily achieving treatment goals that are identified, documented, assessed and updated on an ongoing basis.

B. Purpose

The purpose of this research was:

1. To conduct an in-depth investigation of adolescent personality factors that, in combination with family functioning, are associated with (a) premature withdrawal of the adolescent patient from therapy and (b) successful completion of therapy by the adolescent in treatment.

2. To compare the data obtained from the above samples to identify factors that are differentially predictive of adolescents and families most likely to (a) complete therapy and (b) terminate therapy prematurely.

C. Sample

From a total of 96 families seen in treatment over the two year period September 1985 to June 1987 , a sample of 40 family triads consisting of two parents and an adolescent child, the identified patient, was selected for the study. Of the forty families twenty had completed treatment (*completers*) and twenty had terminated treatment prematurely (*dropouts*). Of the twenty *completers*, eight of the families were biological, seven were blended and five were adoptive, while in the *dropout* sample five were biological, nine were blended and six were adoptive. Of the twenty *completers* six were males and fourteen were females and of the *dropout* sample twelve were males and eight were females. Their ages ranged from 13.5 to 17.5 years (approximate age 14.8 years), (Table 1, Page 65)

Composition of Parental Dyads and Distribution of Adolescents by Sex

	Dropouts N=20	Completers N=20
Biological	5 (25%)	8 (40%)
Blended	9 (45%)	7 (35%)
Adoptive	6 (30%)	5 (25%)
Female	8 (40%)	14 (70%)
Male	12 (60%)	6 (30%)

TABLE 1

Selection of subjects was made from those patients who had been consecutively admitted to the program over the two years under review. This researcher, as a member of the treatment team, was familiar with all the families in treatment, thus to reduce researcher bias selection was done by two research students blind to the study. The samples met the following criteria:

(a) For the *dropout* sample each adolescent :

(i) was Caucasian and lived with Caucasian parents

(ii) lived at home with both parents whether biological, blended or adoptive

(iii) had been in treatment for a minimum of six weeks prior to dropping out

(iv) had been seen in family interviews for a minimum of four sessions

(b) For the sample of *completers* each adolescent :

(i) was Caucasian and lived with Caucasian parents

(ii) lived at home with both parents whether biological, blended, or adoptive

(iii) had received a therapeutic discharge from the program

(iv) had been seen in family interviews for a minimum of four sessions

Data Collection

Data concerning family dynamics, demographic information and adolescent psychiatric symptomatology are routinely collected at intake. This is done by trained diagnostic staff and takes place over a two-week period. Patient and family are assessed individually and as a unit. This information is compiled together with detailed progress notes charted on an ongoing basis in each adolescent's file. Information routinely documented include assessment of the adolescent's functioning in group therapy, school groups and in bi-weekly family interviews at which time family functioning is also evaluated.

D. Research Hypotheses and Questions

The central research question in this study was to examine the extent to which selected personological and situational variables of adolescents and parents in therapy were indicators of termination from treatment. The following are the hypotheses that were examined:

(1) Family dysfunction, was positively related to treatment termination.

(2) Behavioral characteristics of adolescent patients were differentially indicative of terminators and completers.

(3) Severity of psychopathology, and family dysfunction, were positively related to treatment termination.

(4) Chronicity of adolescent psychopathology and degree family dysfunction were positively related to treatment termination.

(5) Under conditions of stress the greater the degree of family dysfunction, the greater the potential for termination.

E. Methodology

To accomplish the goals of this study required the selection of specific assessment tools and techniques that fit the phenomenon of interest and the appropriate level of the family system. This implementation of "diagnostic technology", as Draguns and Phillips (1971) call it, was dictated by this researcher's viewpoint and purposes.

This researcher was fortunate in having several sources of data available. A demographic questionnaire and a battery of standardized research assessment instruments at the patient (adolescent) and systems (family) levels are routinely administered at the intake phase of treatment at the clinic, and as a member of the treatment team data on individual adolescent patient and family in treatment were also available. Families entering treatment did so with a signed consent for data to be used for research purposes. Confidentiality was ensured by altering numerous details of the cases selected.

A design involving the examination of objective and subjective data was selected for this study. Structured pen and pencil tests in combination with diagnostic impressions and progress notes collected and charted on an ongoing basis were the source of data. The rationale for investigating both objective and subjective data is an acknowledgement, by this researcher, of the importance of not only what members of a family say or believe about themselves or each other, but also how they are perceived to respond as individuals and as a unit on an ongoing basis while in therapy.

A number of commentators have warned that most "family" research is based on data produced by individual family members who provide information *about* their families, rather than on data obtained by studying families directly or including several family members in the same data collecting process (Hodgson and Lewis, 1979).

F. Assessment Instruments

The instruments used in this study have demonstrated their utility and effectiveness in years of ongoing application at the program. In initial

assessments they have effectively identified individual and family pathology, discriminating between adolescent patients with disorders the program staff have the expertise to address, and those that require more intensive and/or specialized intervention (eg. floridly psychotic, suicidal or severely depressed adolescents). Their effectiveness as research instruments have also been demonstrated in providing empirical confirmation of observed improvement in functioning when pre and post test scores of patients and families are compared.

The following instruments were used to assess the psychiatric symptomatology and functioning of the adolescents and their parents and the socio-demographic characteristics of the family:

1. **The Child Behavior Checklist** (Achenbach, 1978; Achenbach and Edelbrock, 1981). This is a questionnaire completed by the parent and designed to record in a standardized format the behavior problems of children aged 4 - 16 years. A typology of behavior profile patterns has been developed for items scored on the CBCL. Separate profile types have been identified for each sex at ages 6-11 and 12-16. The profile types can be combined into clusters that represent either an internalizing pattern of scores, an externalizing cluster, or a mixed group (Edelbrock & Achenbach, 1980).

The following are sample items from the CBCL:

> Below is a list of terms that describe children. For each item that describes your child **now or within the past 6 months**, please

circle the **2** if the item is **very true** or **often true** of your child. Circle the **1** if the item is **somewhat** or **sometimes true** of your child. If the item is **not true** of your child, circle the **0**. Please answer all items as well as you can, even if some do not seem to apply to your child.

0	**1**	**2**	1. Acts too young for his/her age
0	**1**	**2**	7. Bragging, boasting
0	**1**	**2**	10. Can't sit still, restless, or hyperactive
0	**1**	**2**	22. Disobedient at home

Reliability

Interclass correlations (ICC's) between item-scores on the CBCL obtained from mothers and fathers of clinically referred children and demographically matched triads of children has been established in the 90's. The median Pearson correlation between parents (mothers and fathers) ratings was .66 with nominally significant differences occurring in only 1.6% of the comparisons. This fact highlighted the potential importance of those ratings in this study in which major disagreements were found between the mother and father of the adolescent in treatment.

Validity

Content Validity: The CBCL has demonstrated significant content validity in terms of the relationship of its items to the clinical concerns of parents and mental health workers. Of the 118 behaviour problem items, 116

were significantly ($p<.01$) associated with clinical status established independently of the CBCL.

Construct Validity: Correlations between the total CBCL behaviour problem score and total scores on other widely used parent rating forms are as high as those typically found between tests of general intelligence, eg. Conners (1973) Patient Questionnaire and Quay Peterson (1983) Revised Behaviour Problem Checklist.

2. **The Symptom Checklist-90 R** (Derogatis, 1977). This is a multidimensional symptom inventory designed to measure symptomatic psychological distress. It measures psychopathology in terms of 9 primary symptom dimensions as well as global indices of distress. The symptom dimensions include constructs reflecting Somitization, Obsessive-Compulsive Behaviour, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation and Psychoticism. The SCL-90 R was completed by the adolescents and used to assess their symptomatology.

The following as sample items from the Symptom Checklist-90 R :

Example	Descriptors
HOW MUCH WERE YOU DISTRESSED BY	1. Not at all
	2. A little Bit
Ex. Body aches.....Ex.3	3. Moderately
	4. Quite a bit
	5. Extremely

The nine primary symptom dimensions provide a profile of the patient's status in psychopathological terms. They communicate information on the nature, as well as the intensity of the individual's psychological symptoms, and provide important data concerning the pattern of a patient's symptomatology, and whether or not it coincides with any of the standard, clinically recognizable disorders (Derogatis, 1975).

Reliability

Reliability measures on the nine primary symptom dimensions of the SCL-90 R are of two types : Internal consistency and Test-Retest. The internal consistency measures were calculated from the data of 219 "symptomatic volunteers". Using the coefficient alpha, a multi-point variation of the Kuder-Richardson 20 formula, coefficients ranging between a low of .77 for Psychoticism and a high of .90 for Depression were obtained.

Test-Retest reliability was established with a sample of 94 heterogeneous psychiatric out-patients over a one week period. Coefficients obtained ranged between .80 and .90, an appropriate level for measures of symptom constructs. Vascilliation in psychological symptoms over a one week period would not be expected to be great.

The instrument has also demonstrated excellent levels of invariance for all nine symptom dimensions across the parameter of sex. High levels of agreement were obtained between males' and females' structural definitions of eight of the nine dimensions with moderate levels of agreement on the ninth.

Validity

The SCL-90 R has shown a high degree of convergent validity with the MMPI scales (Derogatis, Rickles and Rock, 1976), for clinical, content and cluster scales. Each dimension of the SCL-90 R had its highest correlation with a like construct of the MMPI scales except in the case of Obsessive - Compulsive for which there was no directly comparable MMPI scale.

3. **The Family Assessment Device** (Miller, Epstein, Bishop & Keitner, 1984) is a 53-item, self report scale which assesses seven dimensions of family functioning. The dimensions are Problem-Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behavior Control and General Functioning. This measure was used to assess degree of family dysfunction and was completed by adolescents and also by their parents.

The *Problem Solving* scale assessed the family's capacities to resolve problems within and outside the family at a level which promotes healthy functioning. The *Communication* scale assessed the clarity and directness with which the family communicated. The *Roles* scale assessed patterns of behaviour routinely used in executing family tasks. *Affective Responsiveness* scale assessed the extent to which individual family members were able to sensitively and appropriately respond to varying situations. The *Affective Involvement* scale assessed the involvement and interest demonstrated by family members in the activities of each other. The *Behaviour Control* scale assessed the methods used by the family in expressing and maintaining standards of behaviour of family members. The *General Functioning* scale assessed the overall health/pathology of the family.

The following are sample items from the FAD:

Please read each statement carefully, and decide how well it describes your own family.

You should answer according to how you see your family.

For each statement there are 4 possible responses:

Strongly Agree	(SA)
Agree	(A)
Disagree	(D)
Strongly Disagree	(SD)

6. In times of crisis we can turn to each other for support.

____SA ____A ____D ____SD ____

15. Family tasks don't get spread around enough.

____SA ____A ____D ____SD ____

31. There are lots of bad feelings in the family.

____SA ____A ____D ____SD ____

Reliability

Test-retest reliability of the FAD has been estalished with two other well-known and emperically validated self-report family assessment and instruments - the Family Adaptability and Cohesion Evaluation Scales II (Olsten, Portner, and Bell, 1982) and the Family Unit Inventory (Miller et al, 1985). The test-retest estimates for the seven scales were as follows: Problem Solving .66, Communications .72, Roles .75, Affective Involvement .67, Behaviour Control .73 and General Functioning .71.

Validity

Discriminate validity of the FAD has been established by comparison with clinical assessment based on the McMaster Model of Family Functioning. This was obtained with psychiatric patients and their families. FAD scores of families rated by the clinician as unhealthy on the six dimensions of the McMaster Model had significantly higher family mean scores (poorer functioning) on that dimension for every dimension except behaviour control which approached significance ($p = .12$).

Health/Pathology Cut-Off Scores

In addition to differentiating healthy from unhealthy families the FAD also has specific cut-off scores that discriminate significantly between psychiatric and non-clinical families.

The FAD response categories range from 1 to 4, thus a mean of greater than 2.0 indicates that a greater number of items have been endorsed in an unhealthy direction than in a healthy direction. The FAD also has established sensitivity and specificity cut-off scores (Galen and Gambino, 1975, Vecchio, 1966). When used with psychiatric families the proportion of those functioning in the healthy range were found to be between 32% - 54% (Epstein et al. 1981), reaffirming that not all families with a severely distrubed member show significant dysfunction, and that even families with some difficulty may show healthy functioning on some dimensions.

4. **Demographic Questionnaire.** A demographic questionnaire developed by the programme was used to collect sociodemographic information on both

the adolescent and his/her family; it included age, sex, birth order, number of siblings, school information, and salient past history.

5. **Progress Notes.** Detailed progress notes were charted routinely on an ongoing basis for each adolescent and included individual, gorup and family functioning; also included were weekly clinical consultations with medical, therapeutic and educational staff. These notes summarized salient information for the total therapeutic period up to termination.

G. DATA ANALYSIS

This study examined self-report and behavioural data on the functioning of family triads composed of a mother, father, and adolescent son or daughter in which the adolescent was the identified patient. The objective was to examine the relation between "dropouts" versus "completers" of therapy on the basis of the following theoretically significant variables: Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement and Behaviour Control.

It was hypothesized that adolescents living in families reporting moderate to severe difficulty in a majority of these areas would be highly representative in the dropout population. These variables were classified into familiar clinical categories routinely used by the treatment team in discussing and charting on individual adolescent patients. Categories relevant to this study were as follows:

Family cohesion: an emotional, intellectual and/or physical oneness that family members feel toward one another. This incorporates *affective involvement* and *communication*. These variables range from extremely high cohesion resulting in over identification or enmeshment with the family, to extremely low family cohesion which results in isolation or disengagement within the family.

Family adaptability: the family's ability to shift its role relationships, and relationship rules in response to situational and development stress. This incorporates *Roles* and *Behaviour Control*. Adaptability ranges from extreme change, which results in chaos, to limited change which results in system rigidity.

Family support: the expression of acceptance, appreciation, recognition, praise and encouragement, or liking given or received by the other family members. This incorporates *Affective Responsiveness* and is negatively related to criticism and put-downs of other family members.

Family Creativity: the ability to produce a large *number* and *variety* of alternative solutions in a problem-solving situation. This incorporates *Problem Solving*.

The families in this study were all considered dysfunctional and were selected on the basis of those whose adolescent failed to complete therapy ("dropout") and those whose adolescent completed therapy ("completer").

Objective Analysis

Individual Data: When data from a single family member are utilized without reference to the views, perceptions, or actions of other family

members, such measurement occurs at the "individual" level of assessment (Arias and O'Leary, 1981). Strictly speaking statements derived from such data reflect only the particular respondent's views and do not apply to a quality of the family unit or system. Thus, although, for example, each adolescent's scores may have considerable value in their own right, and may be highly predictive of a range of outcomes and related variables, such individually based scores reflected the actions of a single member of each family without reference to that system. Consequently, they reflected only that element's behavior or perspective as an isolated object and in this sense were not viewed as "family" data.

Relational Data: When individual-level data collected from two or more family members are "related" to each other by the researcher they are no longer a reflection of a single family member, as in individual level data, instead they are descriptive of the *combined* products of individual family members. From these two or more individual data sets, a single, new score representing a previously defined characteristic of the contributing individuals' combined scores was computed. In this manner, the responses of individual family members were combined to derive a score that reflected characteristics of the family unit. Statements made from these data referred to characteristics *about* the family in so far as they referred to a quality of family members' perception of some aspects of their attitudes or attributes.

Subjective Analysis

Transactional Data: Attempts were made by this researcher to define the *life-space* of the adolescent and then conceptualize the raw data of the

patient-family-environment interaction so that neither the adolescent, his/her family, nor the environment had an absolute value, but rather had value or meaning in terms of each other. Thus, stressful events in the treatment process which influenced treatment negatively or positively (identified by reported responses of the adolescent and his/her parents) became more evident, more understandable. This transactional data, when incorporated with objective measures provided measures *of* the family that reflected behavioural interchange among system members. This provided a transactional unification of the system's elements into a whole that was significantly different from the sum of the parts obtained from the objective analysis of the pen and pencil data.

Research Considerations

The interrelationships of the treatment-evaluation and research components of this project merit consideration because research agendas can undermine the effectiveness of treatment evaluation by making it unduly complex. The primary interests of this researcher were prognostic: What patient characteristics, treatment-process variables, and family functioning were differentially predictive of terminators and completers? This initially led this researcher to investigate a large number of variables, which proved cumbersome because more information was generated than could be assimilated. Thus, to make the data more clinically useful, the number of variables were reduced to a more workable number, which represented a compromise between comprehensiveness and efficiency.

Progress Notes

Stressful situations were identified and charted by therapy staff during the course of treatment. For the purpose of analysis, stressful events were classified as *mild*, *moderate* or *severe*, and family functioning was classified as *Good* or *Poor*. Predictions regarding changes in family functioning as a result of stress necessitated the following assumptions (1) that mental health was not so good or so bad that it could not either improve or deteriorate; (2) that family support was positively valued by family members, and that lack of it was stressful. Stressors were allowed to take three values '*Mild*', '*Moderate*', or '*Severe*'. The assumption was also made that the higher the initial level of family support the greater the degree to which this level would be maintained when stressful situations occurred.

Data Tabulation

The ratings obtained from the assessments of each of the forty family triads were individually graphed to display a profile of behaviour (CBCL), psychopathology (SCL-90 R), and family functioning (FAD) for each patient. A four point rating scale (0-3) is routinely used at the programme in recording and reporting all diagnostic assessments; ongoing evaluation of patient and family functioning is also reported on a four point scale (0-3). On all scales a lower rating indicates healthier functioning whereas a higher rating reflects more disturbed functioning.

For the purposes of this study all scales were tabulated in the same frame to facilitate comparisons, however, because of the lack of exact

psychometric intervals, this researcher had to use caution in making comparisons.

Important Considerations

An important consideration when evaluating the results of this study is the fact that the assessments used and focus taken are aimed at improving the ongoing work at the program. As such, it falls within the scope of "action research" (Isaac and Michael, 1971) which sacrifices scientific rigor for clinical richness and practical utility. However, the cost in objectivity is offset somewhat by the richness of the data gained through its provision by those persons most knowledgeable about the patients and their treatment.

Variables

1. Family Assessment Device (FAD)
   - PS Problem Solving
   - CO Communication
   - RO Roles
   - AR Affective Responsiveness
   - AI Affective Involvement
   - BC Behaviour Control
   - GF General Functioning

2. Child Behaviour Checklist (CBCL)

SOM	Somatic Complaints
SCH	Schizoid
UNCOM	Uncommunicative
IMM	Immature
O-C	Obsessive-Compulsive
H-W	Hostile Withdrawal
DEL	Delinquent
AGG	Aggressive
HYPER	Hyperactive

3. Symptom Checklist-90 R (SCL-90 R)

SOM	Somatisation
O-C	Obsessive-Compulsive
I-S	Interpersonal Sensitivity
DEP	Depression
ANX	Anxious
HOST	Hostility
PHO	Phobic
PAR	Paranoid
PSY	Psychoticism

4. Chronicity of Psychopathology

5. DSM III-R Categories of Stressors

Mild

Moderate

Severe

6. Family Stressors

Martial Discord

Financial Difficulty

Illness in the Family

Alcoholism/~~Drug~~ Use

Emotional/Physical/Sexual Abuse

Serious Legal Involvement

IV. RESULTS

Chapter IV summarizes the data obtained for the two major subgroups of adolescents and parents who participated in this research project --- (a) family triads of mothers, fathers and adolescent sons or daughters who were in treatment and terminated non-therapeutically *dropouts*, and (b) corresponding family triads who were discharged therapeutically *completers*. In order to test the five hypotheses postulated in Chapter III, data from the Family Assessment Device (FAD) were compiled and graphical profiles of the sample of family triads of *dropouts* and *completers* were plotted and compared. These profiles provided a framework for examining the major patterns on the scales identifying functioning of families from the perspective of mothers, fathers and adolescents comprising the triads.

This process was replicated for the two groups of adolescent *dropouts* and *completers* using data obtained from the scales of the Child Behaviour Checklist (CBCL) and the Symptom Checklist-90 R (SCL-90 R). Additionally an examination of the occurence of stressful episodes during the treatment phase and their timing in relation to the dropout process was conducted. Chronicity of dysfunction, obtained from the documented history of each adolescent, was evaluated for trends relating to the dropout process. In conducting the analyses, assessments for consistent patterns were made and evaluated. The assumption underlying these procedures is that self-report data completed by families in therapy, in conjunction with expert assessments can provide crucial information for early identification of potential dropouts from therapy.

Hypothesis #1

Family dysfunction was positively related to treatment termination.

To test this hypothesis involved a series of comparisons of FAD subscale ratings of dyads and triads of fathers, mothers and adolescents *within* and *across* samples of *dropouts* and *completers*.

The means and standard deviations of fathers, mothers and adolescents on the seven subscales of the FAD for both *dropouts*, N = 20, and *completers*, N = 20, were computed. Using a degree of freedom of 38 and a .05 level of significance, a critical t value of 2.03 was established and t values within samples computed, Tables 2 and 3.

Severity of dysfunction was determined by subscale means obtained from established cut-off scores. Means exceeding 1.3 indicated that a greater number of items on these subscales were endorsed in an unhealthy direction than in a healthy direction. Theoretically that suggested that the family was having difficulty with those areas of functioning.

Tables 2 and 3 provide t values for *within* samples comparisons for *dropouts* and *completers* respectively; Figures 1 and 2 show corresponding profiles for the two samples.

A. Within Samples Comparisons - *Dropouts*

Fathers vs. Mothers

Mothers and fathers showed no significance in ratings on any of the seven FAD subscales.

Table 2

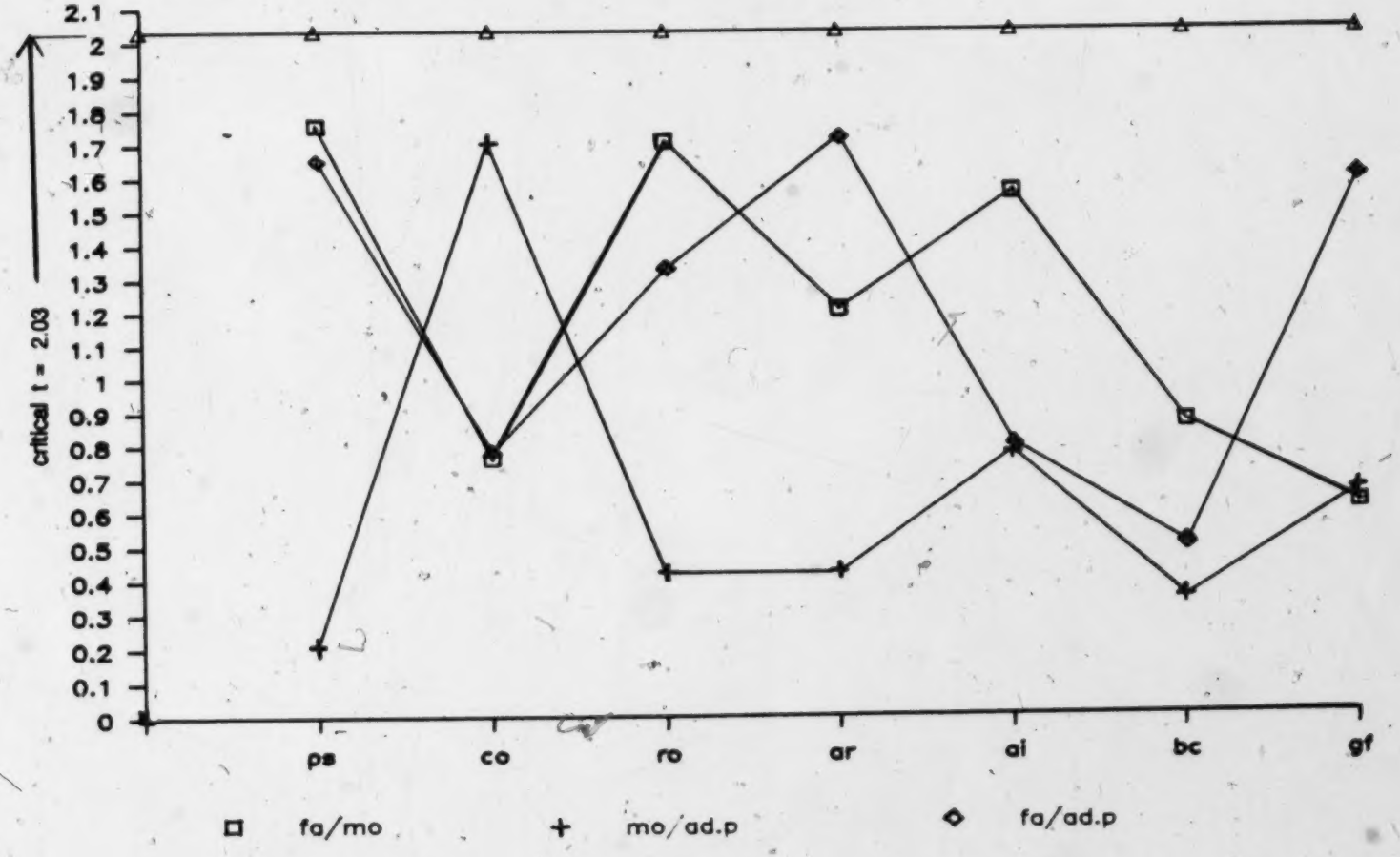
Means, Standard Deviations and t Values of Within Samples Comparison on FAD subscales - *Dropouts*

	Fathers		Mothers		Adolescents		Fathers vs. Mothers	Mothers vs. Adolescents	Fathers vs. Adolescents
	x	SD	x	SD	x	SD	t	t	t
PS	1.90	.49	2.18	.46	2.14	.41	1.75	.21	1.64
CO	2.22	.59	2.09	.50	2.35	.45	.75	1.70	.77
RO	2.23	.41	2.00	.46	2.05	.43	1.70	.42	1.32
AR	2.38	.35	2.21	.51	2.14	.50	1.20	.42	1.71
AI	2.37	.35	2.15	.51	2.27	.42	1.55	.78	.79
BC	2.22	.41	2.10	.46	2.15	.46	.86	.34	.49
GP	2.34	.31	2.26	.48	2.17	.35	.61	.66	1.59

Critical t = 2.03, p = .05, df = 38

* Significant

Figure 1 Profile of t Values of Within Samples Comparison on FAD subscales - *Dropouts*



Mothers vs. Adolescents

Mothers and adolescents showed no significance in ratings on any of the seven FAD subscales.

Fathers vs. Adolescents

Fathers and adolescents showed no significance on any of the seven FAD subscales.

B. Within Samples Comparisons - *Completers*

Fathers vs. Mothers

Significance was obtained between fathers and mothers on four of the seven FAD subscales --- Affective Responsiveness ($t = 2.28$), Affective Involvement ($t = 2.78$), Behaviour Control ($t = 2.41$) and General Functioning ($t = 3.57$).

Mothers vs. Adolescents

Mothers and adolescents showed no significant difference on any of the seven FAD subscales.

Table 3

Means, Standard Deviations and t Values of Within Samples Comparison on FAD subscales - *Completers*

	Fathers		Mothers		Adolescents		Fathers vs. Mothers	Mothers vs. Adolescents	Fathers vs. Adolescents
	x	SD	x	SD	x	SD	t	t	t
PS	1.92	.56	1.71	.49	1.69	.28	1.23	.15	1.60
CO	2.03	.51	1.81	.60	1.93	.42	1.23	.72	.66
RO	1.91	.40	1.81	.53	1.88	.39	.66	.46	.24
AR	2.25	.46	1.86	.61	1.93	.38	*2.88	.43	*2.44
AI	2.35	.39	1.94	.51	2.07	.52	*2.78	.78	1.88
BC	2.20	.54	1.80	.48	1.70	.45	*2.41	.66	*3.12
GF	2.27	.50	1.73	.44	1.98	.45	3.57	1.73	1.90

Critical t = 2.03, p = .05, df = 38

* Significant

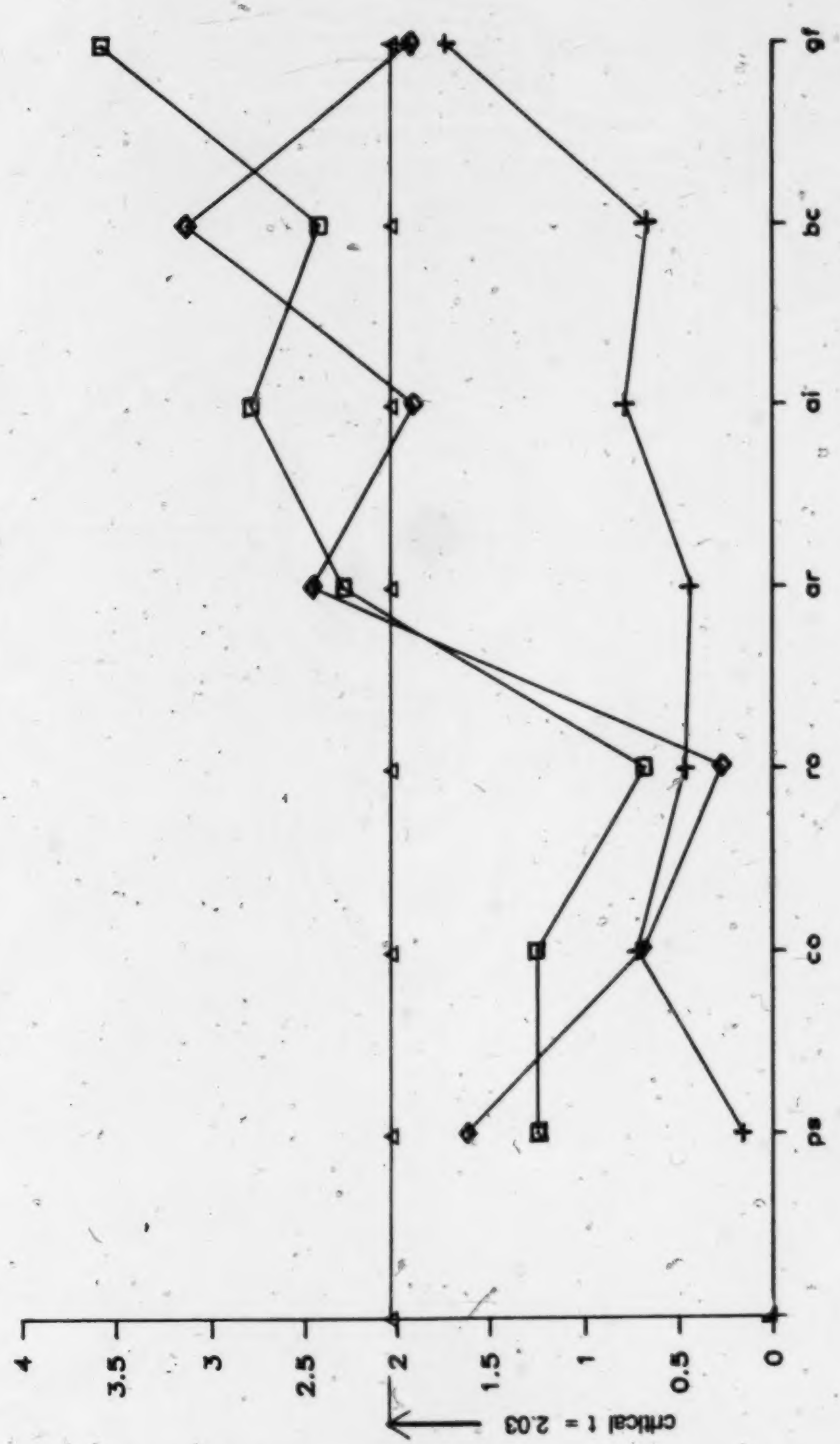


Figure 2 Profile of t Values of Within Sample Comparison on FAD subscales - *Completers*

Fathers vs. Adolescents

There was significant difference between the ratings of fathers and adolescents on two of the seven FAD subscales --- Affective Responsiveness ($t = 2.44$) and Behaviour Control ($t = 3.12$).

C. Across Samples Comparisons - *Dropouts vs. Completers*

Table 4 summarises the results of *across* samples comparisons for fathers, mothers and adolescents, and Figure 3 the corresponding profiles of t values.

Table 4

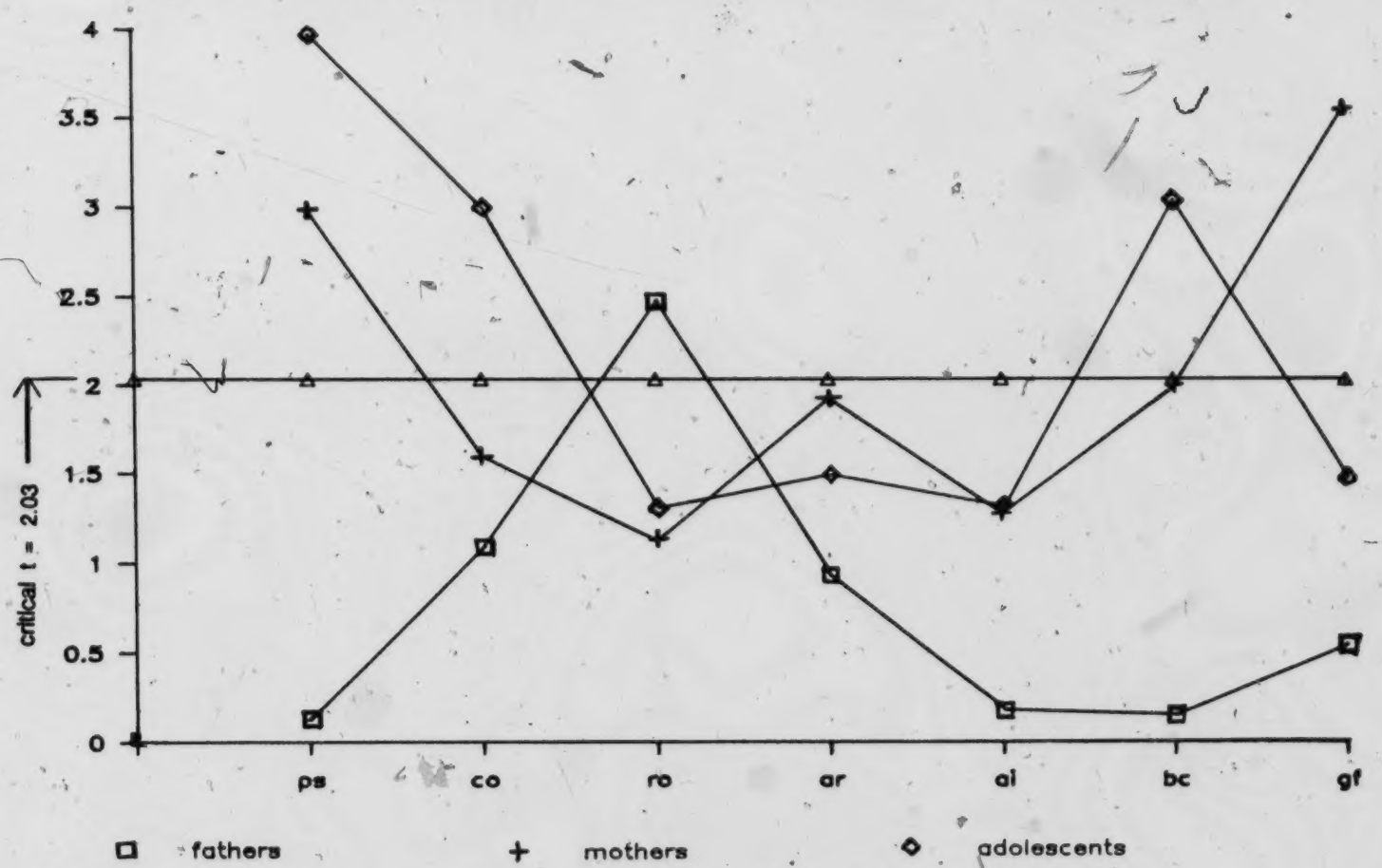
t Values of Across Samples Comparisons (FAD) - Fathers, Mothers, and Adolescents

Subscales	PS	CO	RO	AR	AI	BC	GF
Fathers	.11	1.07	*2.46	.91	.16	.13	.53
Mothers	*2.98	1.59	1.12	1.92	1.27	1.99	*3.55
Adolescents	*3.95	*2.97	1.28	1.47	1.29	*3.02	1.45

critical $t = 2.03$, $p = .05$, $df = 38$

* significant

Figure 3 Profiles of t Values of Across Samples Comparison on FAD subscales - *Dropouts* and *Completers*



Fathers

There was significant difference between the ratings of fathers of *dropouts* and *completers* on one of the seven FAD subscales --- Roles (t = 2.46).

Mothers

There were significant differences between the ratings of mothers of *dropouts* and *completers* on two subscales --- Problem Solving (t = 2.98) and General Functioning (t = 3.55).

Adolescents

There were significant differences between the ratings of adolescents from the sample of *dropouts* and *completers* on three subscales ---Problem Solving (t = 3.95), Communication (t = 2.97), and Behaviour Control (t = 3.02).

Direction of Endorsement of Difference on Subscales In *Within* and *Across* Samples Comparisons

In *across* samples comparisons of ratings of *dropouts* and *completers*, members of the two groups showed the following qualitative difference in scoring pattern on those subscales that were significant --- members of the families of *dropouts* scored consistently higher, more dysfunctional, than *completers* (see Tables 2 and 3 and Appendix A, Figures 3a, 3b and 3c). In

Figure 4 Profiles of Means of Within Sample Comparisons on FAD subscales - *Dropouts*

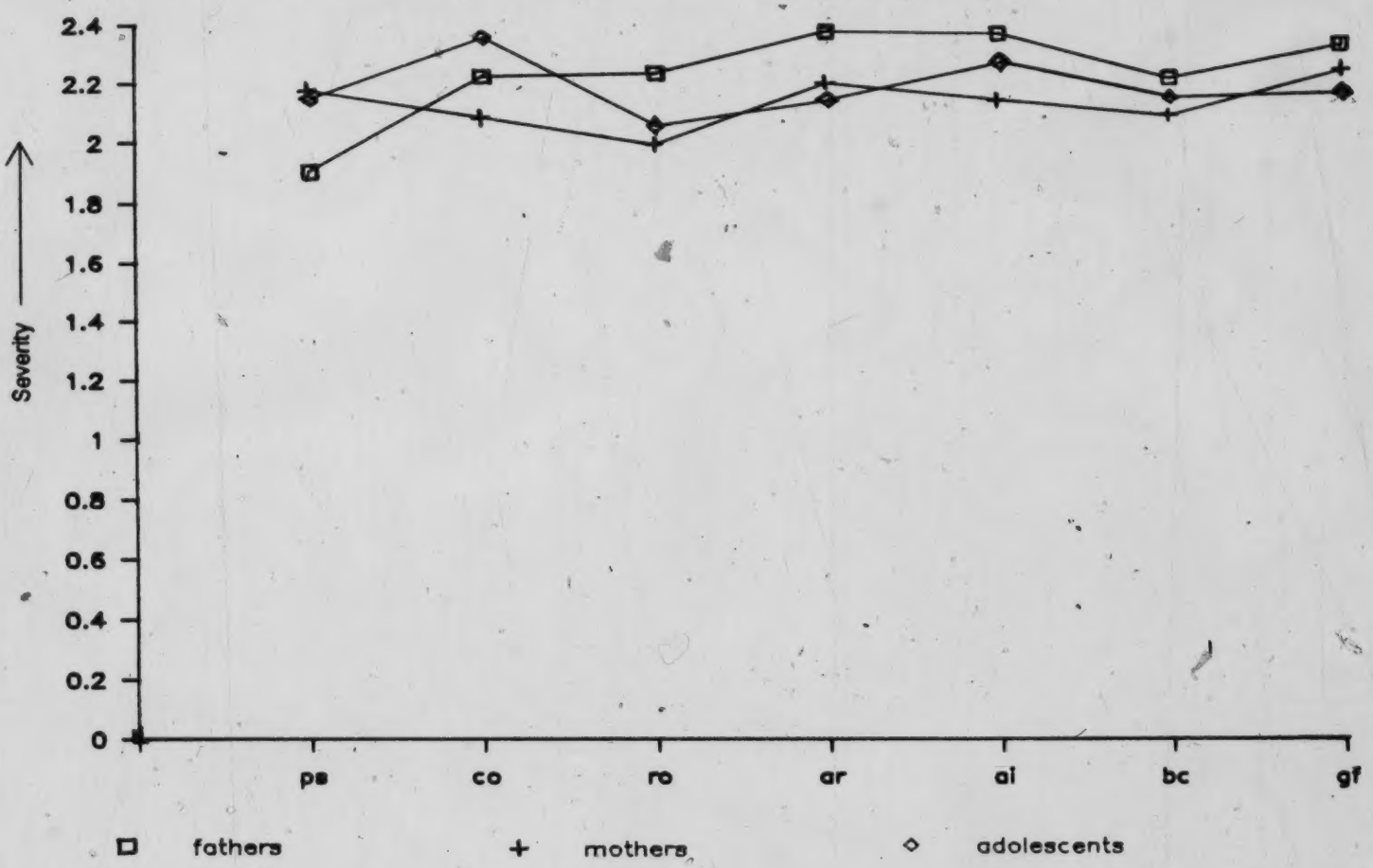
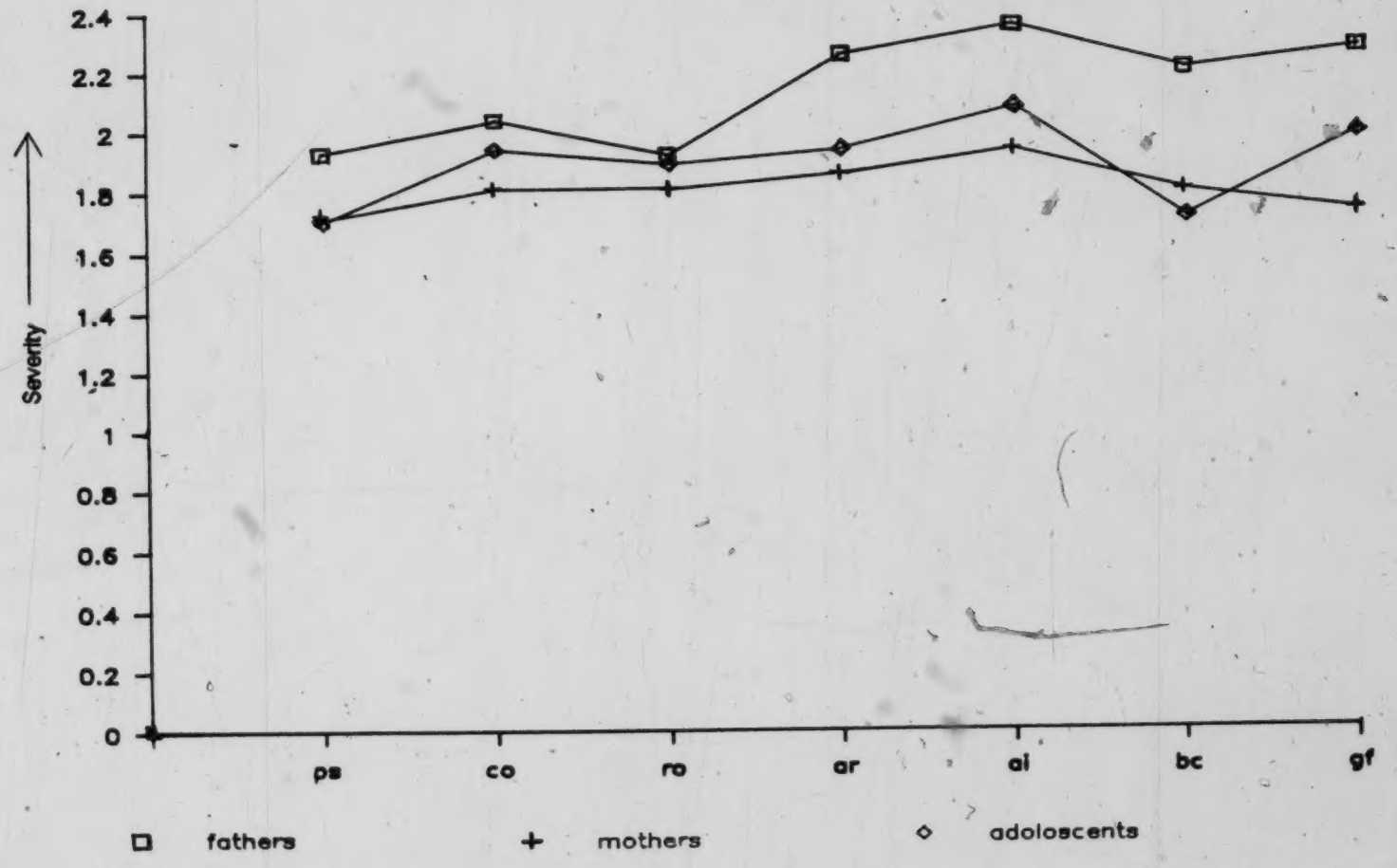


Figure 5 Profiles of Means of Within Sample Comparisons on FAD subscales - *Completers*



within samples comparisons family members of the *dropout* sample endorsed all subscales at levels that were not significant. The resulting profile of means showed extremely high cohesion in subscale endorsements among fathers, mothers and adolescents of *dropout* families, Figure 4. By comparison, the families of *completers* had ratings that were significant on a total of six subscales between two of the three dyads, resulting in a more diffuse profile of means, Figure 5.

The results obtained in comparisons of *within* and *across* samples of *dropouts* and *completers* on the FAD support the premise in Hypothesis #1.

Hypothesis #2

Behavioural characteristics of adolescent patients were differentially indicative of *dropouts* and *completers*.

To test this hypothesis involved a series of comparisons of CBCL subscale scores of dyads of mothers and fathers *within* and *across* samples.

The means and standard deviations for fathers and mothers on the nine subscales of the CBCL for both *dropouts* (N = 20), and *completers* (N = 20), were computed, using a degree of freedom of 38 and a .05 level of significance, a critical t value of 2.03 was established and t values *within* and *across* samples computed, Table 5. Profiles of these comparisons are shown in Figures 6 and 7.

Table 5

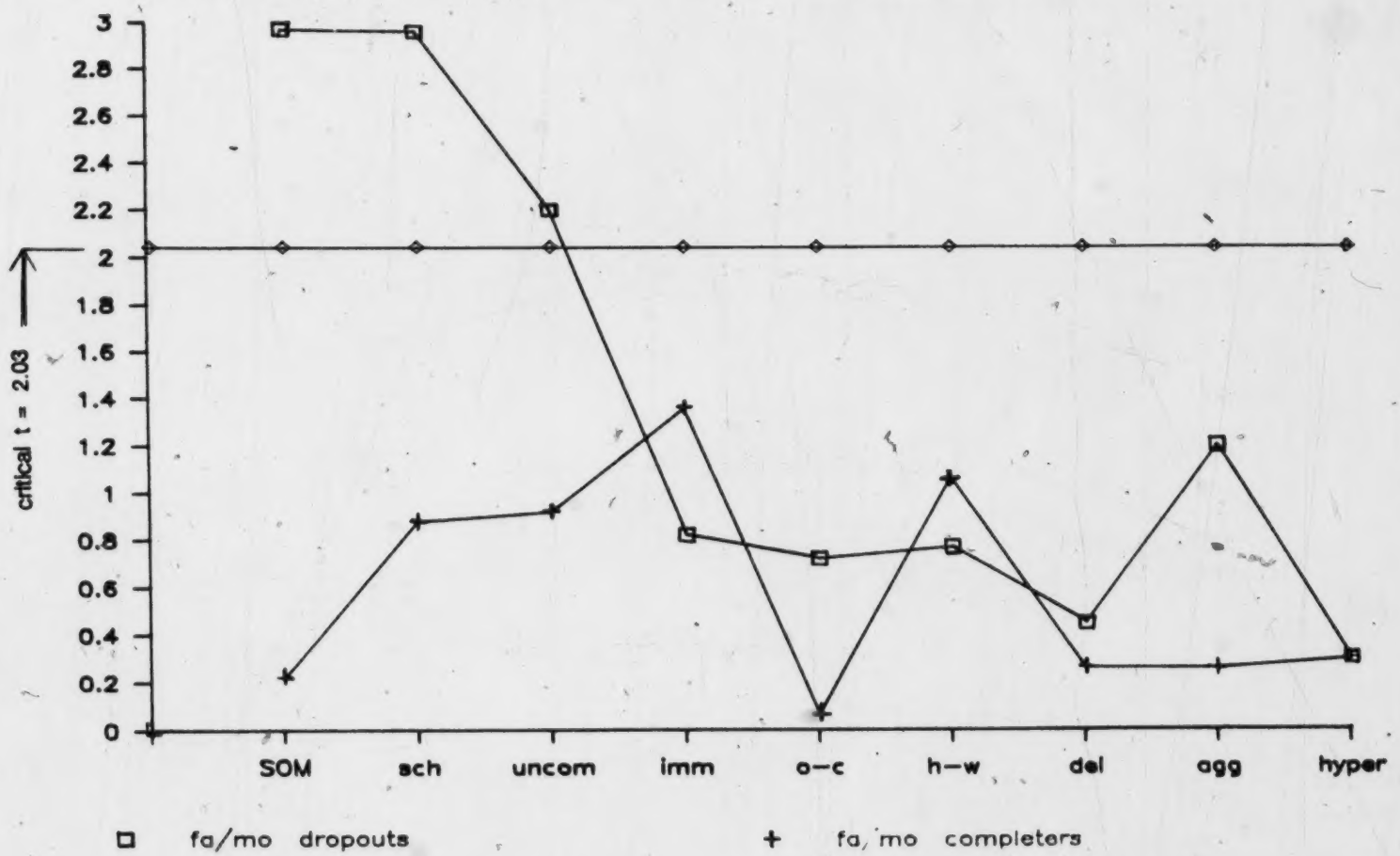
Means and Standard Deviations Within Samples --- *Dropouts* and *Completers* - t Values Within and Across Samples on CBCL Subscales

	Within Sample Dropouts				Within Sample Completers				Within Sample Dropouts	Within Sample Completers	Across Samples	Across Samples
Subscales	Fathers		Mothers		Fathers		Mothers		t	t	t	t
	x	SD	x	SD	x	SD	x	SD	F. vs. M.	F. vs. M.	Fathers	Mothers
SOM	.92	.71	1.57	.64	1.68	.63	1.63	.75	*2.96	.22	*3.49	.27
SCH	.70	.39	1.14	.52	1.17	.68	1.40	.92	*2.95	.88	*2.60	1.07
UNCOM	.91	.64	1.44	.84	1.05	.34	1.18	.51	*2.19	.92	.84	1.15
IMM	1.33	.74	1.15	.60	1.23	.54	1.46	.57	.82	1.36	.48	1.63
O-C	.77	.53	.89	.51	1.21	.55	1.20	.56	.71	.06	*2.51	1.78
H-W	1.61	.75	1.82	.94	1.24	.41	1.41	.57	.76	1.06	1.89	1.63
DELIN	1.67	.75	1.56	.80	.84	.49	.80	.45	.44	.26	*4.01	*3.60
AGGR	1.64	.76	1.33	.85	.92	.44	.96	.51	1.19	.26	*3.57	1.63
HYPER	1.56	.66	1.62	.61	1.12	.59	1.06	.62	.29	.30	*2.17	*2.80

Critical t = 2.03, p = .05, df = 38

* Significant

Figure 6 Profiles of t Values of Within Samples Comparison on CBCL subscales - *Dropouts* and *Completers*



A. Within Sample Comparisons - *Dropouts*

Fathers vs. Mothers

Significance was obtained on three subscales between fathers and mothers of *dropouts* as follows: Somatisation (t = 2.96), Schizoid (t = 2.95) and Uncommunicative (t = 2.91).

B. Within Sample Comparisons - *Completers*

Fathers vs. Mothers

Significance was not achieved on any of the nine subscales between fathers and mothers of *completers*.

C. Across Samples Comparisons - *Dropouts vs. Completers*

Figure 7 shows profiles of t values of *across* samples comparisons.

Fathers

Between fathers of *dropouts* and *completers*, ratings on five of the nine subscales were significant --- Somatisation (t = 3.49), Schizoid (t = 2.06), Obsessive Compulsive (t = 2.51), Delinquent (t = 4.01) and Hyperactive (t = 2.17).

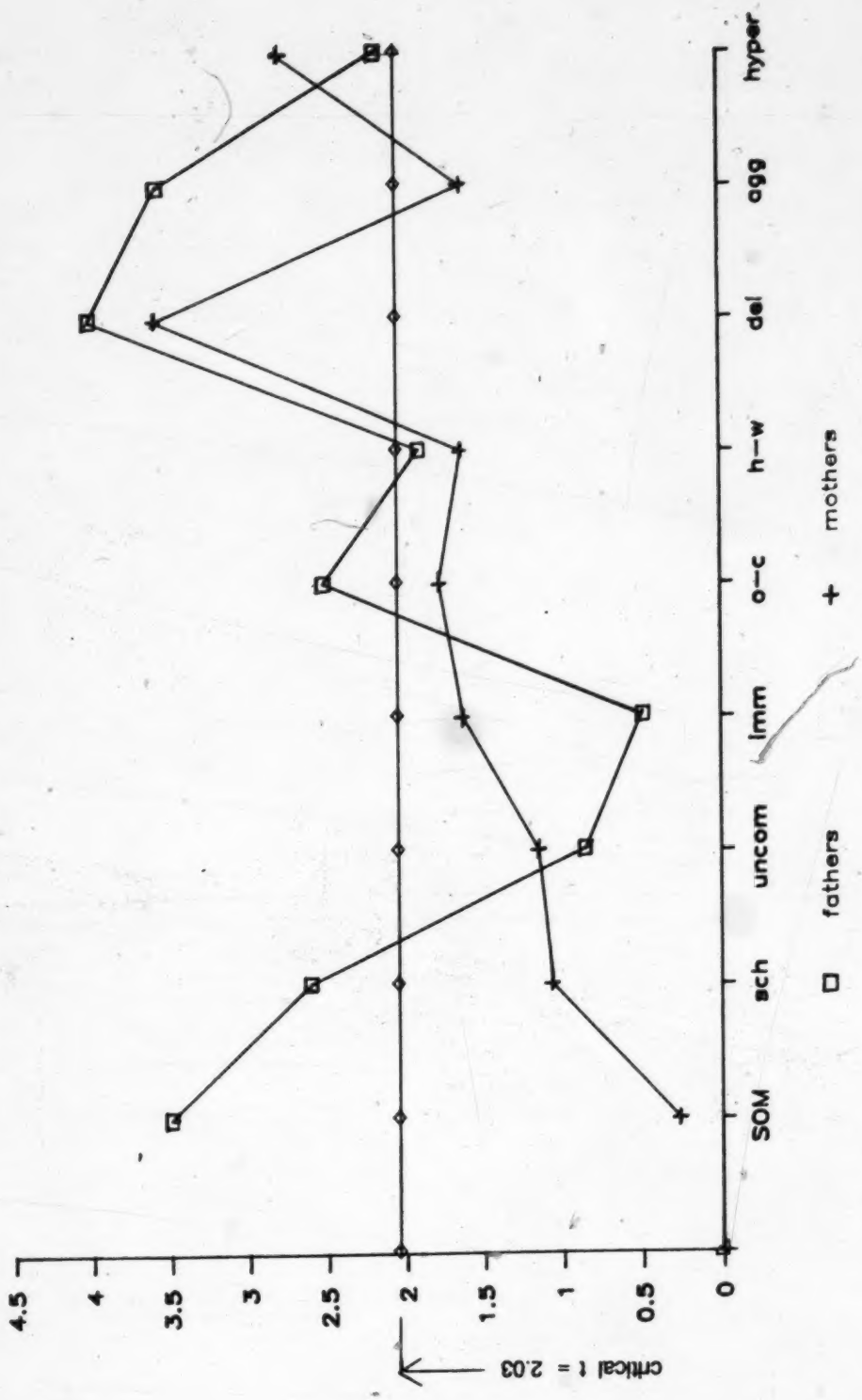


Figure 7 Profiles of t Values of Across Samples Comparisons on CBCL subscales - Fathers and Mothers

Mothers

Between mothers of *dropouts* and *completers*, ratings on two subscales were significant --- Delinquent ($t = 3.60$) and Hyperactive ($t = 2.80$).

Direction of Endorsement of Differences on Subscales in *Within* and *Across* Samples Comparisons

On subscales where statistical significance was achieved *within* and *across* samples of *dropouts* and *completers* on the CBCL, the following profiles identifying qualitative differences were obtained. In *within* samples comparison, parents of *dropouts* achieved statistical significance on three subscales --- Somatisation, Schizoid, and Uncommunicative. These subscales represented problem behaviours on the *Internalizing* cluster. Mothers of *dropouts* endorsed these behaviours as more problematic than fathers (Table 5 and Appendix A, Figure 7a). By comparison, parents of *completers* showed no significant difference in ratings on the subscales (Table 5 and Appendix A, Figure 7b).

In *across* samples comparison between fathers of *dropouts* and *completers*, three of the five subscales that showed significant difference in ratings were located on the *Internalizing* cluster of behaviours and were endorsed as more problematic by fathers of *completers*. However, the remaining two subscales that were significant were located on the *Externalizing* cluster and were endorsed as more problematic by fathers of *dropouts*. Fathers of *completers* endorsed these subscales in the normal range (Table 5 and Appendix A, Figure 7c).

The two subscales on which significance was achieved between mothers of *dropouts* and mothers of *completers* were both located on the *Externalizing* cluster of behaviours. Both were endorsed as more problematic by mothers of *dropouts* than by mothers of *completers* (Table 5 and Appendix A, Figure 7d).

The results obtained in the comparisons of *within* and *across* samples of *dropouts* and *completers* on the CBCL support the premise in Hypothesis #2.

Hypothesis #3

Severity of psychopathology and family dysfunction were positively related to treatment termination.

Means and standard deviations for the nine symptom categories of the SCL-90 R for *dropouts* (N = 20), and *completers* (N = 20) were calculated. Using a degree of freedom of 38 and a .05 level of significance, a critical t value of 2.03 was established. t values on the nine subscales for the two groups were computed, Table 6. Significant difference in severity of symptomatology was obtained between the adolescent *dropouts* and *completers* on two subscale symptoms --- Hostility (t = 2.38) and Psychoticism (t = 2.03) (Table 6 and corresponding profile of t values, Figure 8). On the Hostility subscale *dropouts* scored higher than the *completers*, while on the Psychoticism subscale, *completers* scored higher than *dropouts* (Appendix A, Figure 8a).

Families of *dropouts* were more dysfunctional than families of *completers* (Hypothesis #1), severity of psychopathology showed significant

Figure 8 Profiles of t Values of Severity of Psychopathology of Adolescents - *Dropouts* and *Completers* (SCL-90 R)

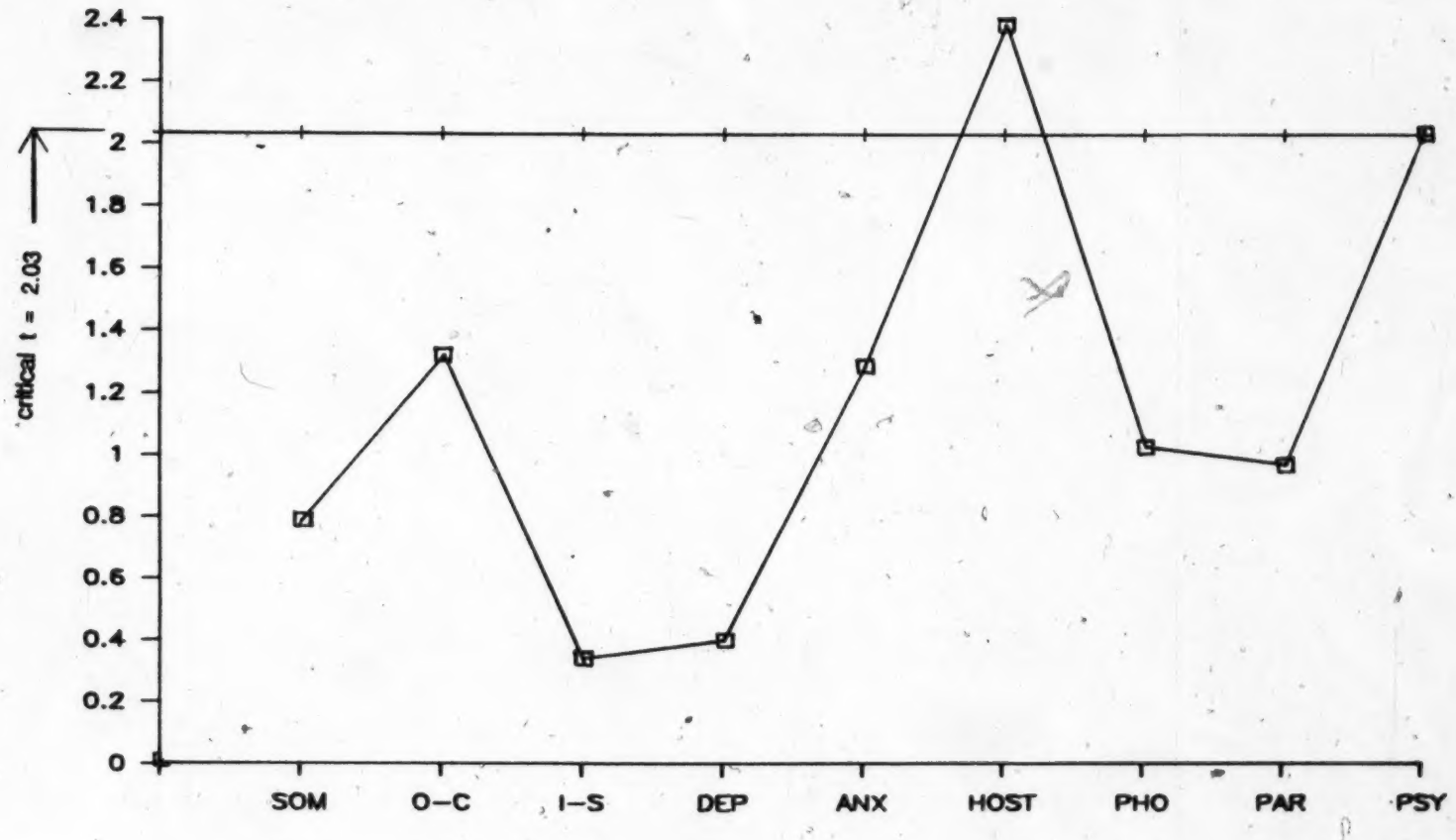


Table 6

Means and t Values Across Samples Comparisons on SCL-90 R subscales --- Adolescents

	*SOM	O-C	I-S	DEP	ANX	HOST	PHO	PAR	PSY
Dropouts	x .75	.94	1.11	1.10	1.20	1.36	.98	1.10	.63
Completers	x .88	1.24	1.03	1.01	.95	.810	.76	.88	1.08
t scores	.78	1.31	.33	.39	1.28	2.38	1.02	.96	2.03

Critical t = 2.03, p = .05, df = 38

* Significant

difference on two subscales between the two samples of adolescents; however, direction of endorsement on these subscales were reversed in the two samples. Consequently, direction of relationship between family dysfunction; severity of psychopathology and treatment termination was inconclusive.

The premise in Hypothesis #3 was not supported by the evidence.

Hypothesis #4

Chronicity of adolescent psychopathology and family dysfunction was positively related to treatment termination.

Data from charts of the two samples of adolescents, *dropouts* and *completers*, Table 7, showed that *dropout* families reported significant problems with their adolescents for periods of from .5 to 10 years, while

parents of *completers* reported problems of from .5 to 7.5 years. The latter had a larger distribution in the lower range while *dropouts* were clustered in the higher.

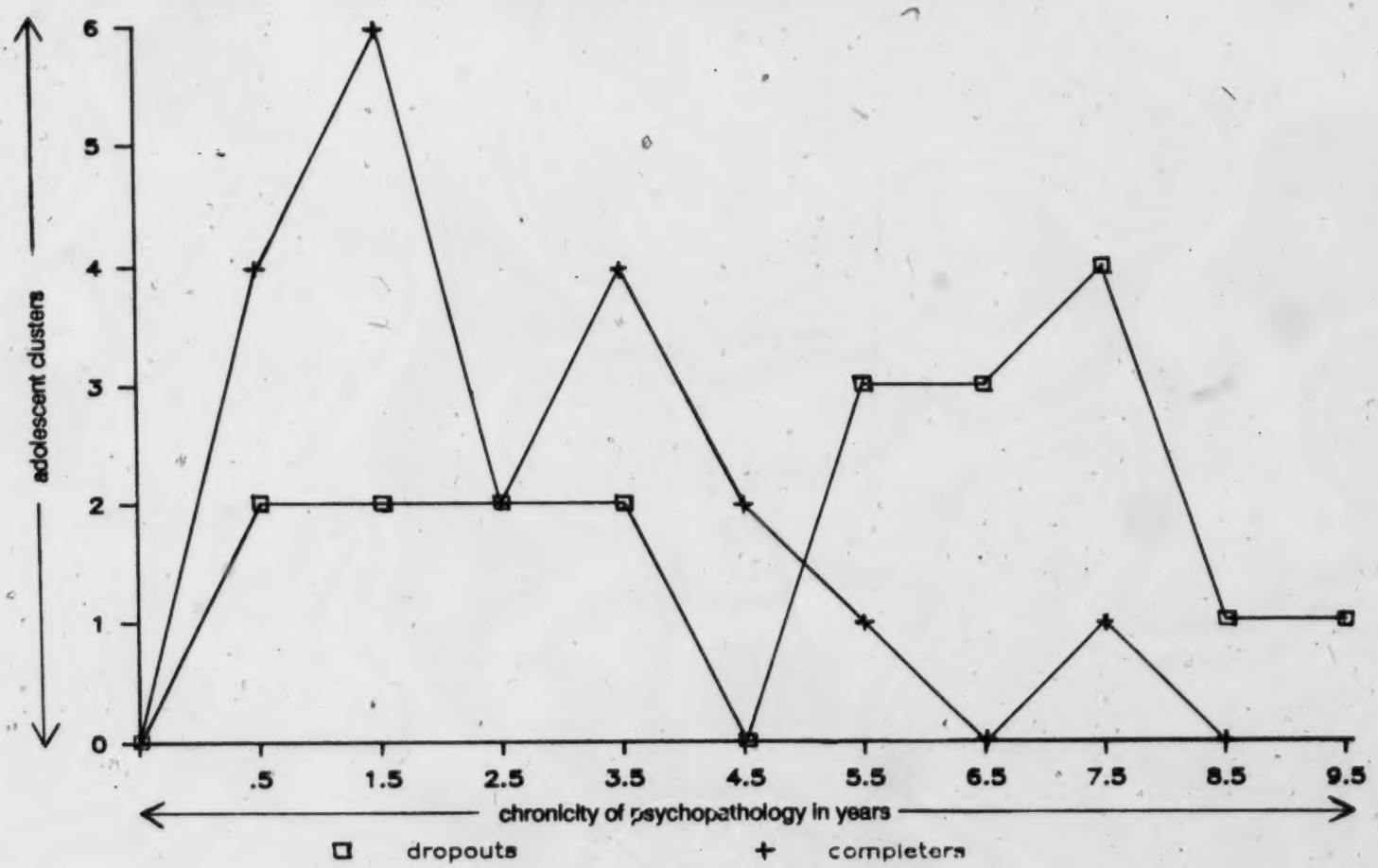
Table 7

Cumulative Years, Means and Standard Deviations of Psychopathology of Adolescents --- *Dropouts* and *Completers*

Chronicity Years	Dropouts	Cumulative Years (Score)	Completers	Cumulative Years (Score)
0.0-0.5	2	0.5	4	0.5
0.6-1.5	2	1.5	6	1.5
1.6-2.5	2	2.5	2	2.5
2.6-3.5	2	3.5	4	3.5
3.6-4.5	0	4.5	2	4.5
4.6-5.5	3	5.5	1	5.5
5.6-6.5	3	6.5	0	6.5
6.6-7.5	4	7.5	1	7.5
7.6-10+	2	10	0	10
Mean		5.1		2.6
Standard Deviation		2.94		1.89
critical t = 2.03, p = .05, df = 38				
t value = 3.12				

Cumulative scores, means and standard deviations for the two groups were computed, and using a degree of freedom of 38 and a .05 level of

Figure 9 Profile of Chronicity of Psychopathology in Years - *Dropouts* and *Completers*



significance, a critical t of 2.03 was established. t values for the two groups based on cumulative years were computed, Table 7, and significance was achieved with (t = 3.12). Figure 9 shows a profile of *dropouts* versus *completers* on years of chronicity.

Families of *dropouts* were more dysfunctional than families of *completers* (Hypothesis #1), adolescent psychopathology was reported to be more chronic by parents of adolescents in the *dropout* sample than by parents of *completers*, at significant difference.

The premise in Hypothesis #4 was supported by the evidence.

Hypothesis #5

Under conditions of stress, the greater the degree of family dysfunction the greater the potential for termination.

Severity of stressors recorded on Axis IV of the DSM III-R were assessed at intake and again at termination. Stressor categories which ranged from mild to severe indicated different levels of impaired functioning, Table 8.

Table 8

Severity of Stressors of *Adolescents --- Dropouts* and *Completers* --- DSM III-R Categories

Severity	Dropouts	Completers
Mild	2	7
Moderate	6	9
Severe	12	4

In each case the levels recorded were for the identified patient who was the adolescent.

Categories of stresses operating in the families were identified and families assigned to categories based on subjective criteria related to *perceived severity*, Table 9. Ongoing progress notes were the source of data.

Table 9

Categories of Family Stessors Endorsed by *Dropouts* and *Completers*

Stressors	Dropouts	Completers
1. Martial Discord	16	11
2. Financial Difficulty	14	10
3. Illness in the family	9	7
4. Alcoholism/Drug Use	13	4
5. Emotional/Physical/ Sexual Abuse	12	3
6. Serious Legal Involvement	4	1
TOTAL	68	36

On the DSM III-R categories, adolescents in the *dropout* sample reported more stressors clustered at the severe and moderate levels than did the adolescents in the sample of *completers* who reported more stressors at the mild and moderate levels and fewer at the severe levels.

The families of *dropouts* endorsed more stressful events, 68, compared to 36 reported for families of *completers*. This indicated that a higher number

of families in the *dropout* sample experienced mulitiple stressors than families in the sample of *completers*.

Stressor Clusters

Multiple stressors operating in the families of *dropouts* showed positive relationship between Alcohol/Drug Abuse, Martial Discord and Physical/Emotional Abuse. In several of those families that reported Abuse (Physical and/or Emotional) and Martial Discord, an alcohol and/or drug problem was present. In the families of *completers*, there were fewer Abuse and Alcohol/Drug problems.

Of note was the observation that on the termination summaries of the 20 adolescents who dropped out 18 were rated by clinicians as *severe* on Axis IV of the DSM III-R (see Appendix B for Representative Termination Summary.

Families of *dropouts* were more dysfunctional than families of *completers* (Hypothesis #1), families of *dropouts* experienced more stressors at more stressful levels than families of *completers*. The premise in Hypothesis #5 was supported by the evidence.

V. CONCLUSIONS AND IMPLICATIONS

This study of dropouts from therapy was cross-sectional and correlational in design and used self-report and subjective data from adolescents, parents and clinicians. Although this method served to account for differences between family members at different levels of the scales there were limitations imposed by its choice: replication is difficult since much of the data was program specific; because the study was retrospective it required involved subjective decisions in the choice of variables. However, these factors did not detract from the significance of the findings which indicated crucial differences between families that terminate treatment prematurely and those that receive a therapeutic discharge.

Hypothesis #1

This hypothesis found some support in the differences indentified between the families of *dropouts* and those of *completers*. Family members of the sample of *dropouts* showed no significant difference in their perception of problems in the family. This pattern is symptomatic of *enmeshment*, in such families there is often blurring of individual ego boundaries, an insistence on total agreement of family members about all issues, and strong prohibitions regarding separation from the family. By comparison, parents and adolescents in the families of *completers* achieved significance in their endorsement of four subscales of the FAD. Two of the four areas in which the parents differed --- Affective Responsiveness and Affective Involvement are worthy of note since they indicate the tendency of mothers to be emotionally more connected, and

fathers to be emotionally more distant in their interfamilial relationships. That fathers of *completers* endorsed these areas as more problematic than mothers can be interpreted as an acknowledgement of a willingness to address them in therapy, and a positive indicator of commitment to treatment. Fathers scored higher than mothers on Problem Solving and Behaviour Control, and higher than adolescents on Problem Solving and Affective Responsiveness. On variables where significance was established, fathers were involved and endorsed those areas of family functioning as needing change. The strong commitment of fathers may therefore be an important factor in success of dysfunctional families in therapy.

The two groups of fathers showed no significant difference in their perceptions of family functioning on any of the seven subscales. The two groups of mothers showed significant difference in their perception. Problem Solving and General Functioning were the two areas where they differed with the mothers of *dropouts* scoring higher on both subscales. Adolescents from the two groups also had areas in which they had significant difference --- Communication and Behaviour Control. In these two areas, adolescents of families that dropped out scored higher than *completers*.

Dropouts and *Completers* endorsed the seven subscales of the Family Assessment Device in patterns that were group specific, hence Hypothesis #1 received some support.

It is difficult to make definitive conclusions with respect to the reasons for the observed differences between *dropouts* and *completers* recorded on the Family assessment Device. However, the results are consistent with our observations that those families with adolescents with chronic psychological

disorders almost invariably presented with a severely dysfunctional system and comprise a large majority of the *dropouts*.

Whether the dysfunction was the result of the chronic severe stress involved in having a severly disturbed family member or whether they reflected the basic, long-term structure of the family is difficult to determine. However, support was found for the hypothesis that dysfunctional families often cling tenaciously to their rigid 'enmeshed' organization in fear of the chaos or loss of control they anticipate, often choosing to leave therapy than risk change. Recently, Reiss (1984) proposed a detailed theory of the impact of stress on the family, which is based on the concept of the shared family paradigm. This is a fundamental set of assumptions (almost never consistently articulated) that manifests themselves in the family's organizational pattern of daily living. This organizational pattern is experienced implicitly by the family through an extended repertoire of background understandings, rituals and codes. Under severe stress the family loses the implicit level of family functioning and explicit rules emerge. If the stress persists, the family may move towards a tyrannical structure. In the final state of the disorganizing process, family members rebel against the "tyrannical power" of the family. Reiss suggests that three outcomes are possible at this point : chronicity, dissolution of the family or reorganization of the family. the better and more flexible families have greater resources to deal with the stresses than those with basically rigid or chaotic organizational structures.

Hypothesis #2

On the Child Behaviour Checklist, which assessed parental perception of their child's behaviour problems, parents of *dropouts* showed no significant

difference in their assessment of the adolescents Externalizing behaviours. However, these behaviours were endorsed at significantly highers levels of dysfunction than parents of *completers*. On the Internalizing subscales, parents of *dropouts* endorsed these behaviours at significantly less dysfunctional levels than parents of *completers*, they also showed significant difference on three of the five behaviours in this cluster. Mothers scored lower than fathers on all these subscales. These differences between parents of *dropouts* could have significance for the parenting styles in these families since parents respond to their children in terms of the perceived problems.

Fathers and mothers of *completers*, like those of *dropouts*, showed no significant differences in their scores on the Externalizing cluster of behaviours, but unlike parents of *dropouts*, they endorsed these behaviours at less dysfunctional levels. In their scores on the Internalizing cluster, parents of *completers* showed no significant differences. They also endorsed those behaviours as being more problematic than behaviours on the Externalizing cluster, and more problematic than did parents of *dropouts*.

When the scores of the two groups of fathers were compared, fathers of *dropouts* scored consistently higher than fathers of *completers*, on five of the nine subscales the difference was significant and occurred on both the Internalizing and Externalzing clusters.

Mothers of *dropouts* also recorded more behaviours as problematic and at more dysfunctional levels than mothers of *completers*, but significant difference was obtained only on behaviours on the Externalizing cluster where the mothers of *dropouts* scored consistently higher than mothers of *completers*. These results show a *trend* for parents in the families of *dropouts* to (a) endorse Externalizing behaviours of adolescents as more problematic than

Internalizing behaviours and (b) show significant disagreement, in their endorsement of how problematic these behaviours were. Parents in the families of *completers* (a) endorsed Internalizing behaviours of adolescents as more problematic than Externalizing, and (b) showed close agreement in their endorsement of how problematic these behaviours were on both the Internalizing and Externalizing clusters.

These results provide some support for Hypothesis #2.

Hypothesis #3 and Hypothesis #4

Severity of psychopathology within the family and chronicity of adolescent psychopathology showed positive correlations with family dysfunction. *Dropout* families recorded higher levels of dysfuntion on the FAD and reported more severe dysfunction and longer histories of multiple problems than families of *completers*. Adolescents in *dropout* families similarly reported more years of problem behaviour than adolescents in families that completed therapy.

These factors all lend support to Hypothesis #3 and Hypothesis #4.

Hypothesis #5

The results of investing variables related to this hypothesis indicated a heavy endorsement of stressful situations operating in the families of *dropouts*. On all six of the identified stressor variables, *dropout* families had a higher representation and this endorsed the premise in Hypothesis #5.

Dysfunctional families which were overrepresented in the sample under study were characterized by continuing parental conflict. Underlying this conflict was the inability of these parents to decide on a mutually satisfactory arrangement regarding the distribution of power in the martial relationship. Of the twenty *dropout* families, seventeen had significant martial conflict that was ongoing throught the course of treatment. In these relationships, both parent sought to have the upper hand, although some sought to control in passive-aggressive ways. The adolescents were invariably drawn into the battles --- first on one side, then on the other. Manipulation, exploitation of vulnerabilities, and blaming were common. Problem solving was inefficient; the family mood was angry and suspicious and affective involvement was poor. Because of the severe dysfunction, when a stressful incident occured, it provoked the same response: increased family conflict. These features were endorsed repetitively in the progress notes of the families that terminated with greater frequency and limited modification over time. The parents of *completers*, although displaying significant dysfunction showed some flexibility in their capacity to change some unhealthy interactions. *Dropout* families also had a generally longer history of the dysfunctional behaviours and adolescent patients who had been experiencing difficulties for three or more years; more than the adolescents in famiies of *completers*.

The frequency of stressors in the *dropout* families was greater and they were multiple. Subtle forms of abuse, emotional or physical, was generally present at some point in the treatment process.

Observations and Recommendations

There is general agreement that working with adolescents from dysfunctional families poses many difficulties, and in the face of the continuing loss of these families from therapy, insights that could result in early identification of potential *dropouts* could save time, effort, and limited resources.

Although each family in the sample of *dropouts* had its own peculiar characteristics, there were some common elements that were more prevalent and intense in these families than in the families of *completers*. The families of *dropouts* were characterized by serious and multiple symptoms often of long duration and high intensity. Many of these families were plagued by abuse exacerbated by drug and alcohol problems. One or both parents were often suffering from some form of psychopathology to which the adolescent patient was reacting. Because of their poor parenting skills, the parents of the *dropouts* were generally overwhelmed by the behaviour of the adolescents and tended to remain intensely child-focused during the early phase of treatment. The histories of the *dropout* families were complicated, there were often reports of failed attempts at treatment, symptom development in family members other than the adolescent patients, multiple family crises and seriously impaired interpersonal functioning.

Although the particular problems with communication, structure and dynamics differed for each *dropout* family, some patterns were obvious --- Communication processes, were, on the whole, negative, blaming, and critical. Problem-solving skills were poor, and attempts to resolve conflict generally developed into outbursts from which the adolescents often attempted to

escape physically. Communication was often unempathetic, although frequently emotional and stressed.

Structurally, there were serious problems with role reversals and role deficiencies, with fourteen and fifteen year olds assigned complete caretaking functions for younger siblings.

In interviews, parents of *dropouts* openly abdicated their parental responsibilities and often stated directly their desire to leave their children. There were intergenerational patterns of unresolved grief, loss, violence and serious psychopathology. A preponderance of these families did not share in activities, and family life centered instead on coping with crisis after crisis with little room for reciprocal relationship-building.

However, in spite of their destructive and dysfunctional systems, many of the *dropout* families retained loyalty to family members. In the face of what they perceived as external threat, they chose, under such circumstances, to leave treatment rather than destroy their dysfunctional allegiance.

Implications

The implications of the foregoing for treatment of potential *dropout* families is crucial if success is to be achieved. The importance of forming a treatment allegiance with these families is vital at the start of therapy. Because these families are entrenched in blame and negativism, joining with them in positive, supportive ways is crucial. As McKinnly (1976), stated, "All worker responses should be ego-enhancing and related to observable facts including facts about feelings" (p. 115). In this regard, Gurman (1978) pointed out that treatment of the dysfunctional family is negatively influenced by therapists with poor relationship-building skills. He stated in addition that

techniques of confrontation and insensitive interpretation early on are particularly culpable. What is required in the initial phases of treatment, therefore, is a particular sensitivity to the families' initial self-presentation; its rules, structure, and established interaction patterns, values and beliefs. Unlike the families of *completers*, families of *dropouts* are heavily invested in their own stabilization, often resorting to old dysfunctional patterns with increased vigor, especially when threatened by imminent breakdown. They can tolerate challenges to their rules only slowly and with thought-out consequences for the family.

As a rule it is not wise to challenge the family to change too soon, except in destructive circumstances such as severe acting-out and excessively negative communication. Allowing different family members to express their various viewpoints about their difficulties is important to the engagement process; however, care has to be taken not to overemphasize differences or encourage members to resolve conflict immediately.

Although potential *dropouts* may require special sensitivity to their rules and "defenses", this does not mean that anything goes. The therapist is responsible for establishing the minimum conditions of treatment, such as controlling verbal or physical violence while avoiding hasty attempts to change the family before making an adequate assessment of the families' overall capabilites and hidden agendas.

Another factor of importance when dealing with potential *dropout* families is the strong possibility that biomedical interventions may be needed and in some disorders indispensible (Johnson, 1980). This is often an important first step in achieving some control over severe symptomatology.

Considering the anxieties and resistances of these families, it is helpful to discuss and predict the impact of even small changes. In addition, cautioning such families to proceed slowly to avoid change they may not want is important. Very often both parents and adolescent patients in the families of *dropouts* frequently desire physical separation from one another and considerable effort should be spent helping these families think through whether separation is the best option.

In helping these families negotiate crises that are often associated with the *dropout* phenomenon, it is helpful to define symptoms in terms of life cycle and developmental concepts, rather than direct transactional terms only. Life cycle interpretations address stages and transitional difficulties which often provide a means to normalize a serious situation. The family can more easily accept the symptom reframed as a problem of family transition than it can accept direct attack on its immediate interpersonal functioning.

The above techniques were discussed in terms of their potential effectiveness in helping families, vulnerable to treatment termination, remain in therapy and successfully negotiate crises. *Dropout* families are generally too punitive, destructive, and ready to blame one another to respond positively to the traditional transactional interpretations, or to respond well to rapid attempts to defocus from the identified patient. Moving more cautiously into these areas, focusing on symptom relief, and establishing positive and constructive treatment alliance are likely to help potential *dropout* families complete therapy successfully.

Implications for Future Research

Because the study is retrospective, correlational and cross-sectional in design, no causal inferences can be derived from the results. Additional research involving prospective and longitudinal strategies is needed to clarify the specific ways in which family process variables, chronicity of psychopathology, and stress influence the dropping-out process. To achieve this it will be important to maintain an ecological focus in which emphasis is placed on (a) the family system, (b) the reciprocal interactions that occur among the members, and (c) the family's interactions with the treatment variables.

It should be emphasized that the group-comparison procedures used in this study masks differences that may exist between each type of family structure as well as individual differences among family members. Future studies should compare different family structures and obtain corroborative information from diverse sources. It will also be important to include non-white families as part of the sample.

In accordance with the view that the dropout phenonmenon is a function of multiple interacting systems, future studies should address how these factors mediate or buffer the pathogenic effects of stress that are common or unique to differing family structures.

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APPENDICES

APPENDIX A

1. Figures of Across and Within Samples Comparisons of Means of Dropouts and Completers on the FAD, CBCL and SCL-90 R

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Figure 3a Comparison of Fathers Across Samples on Family Functioning Variables (FAD)

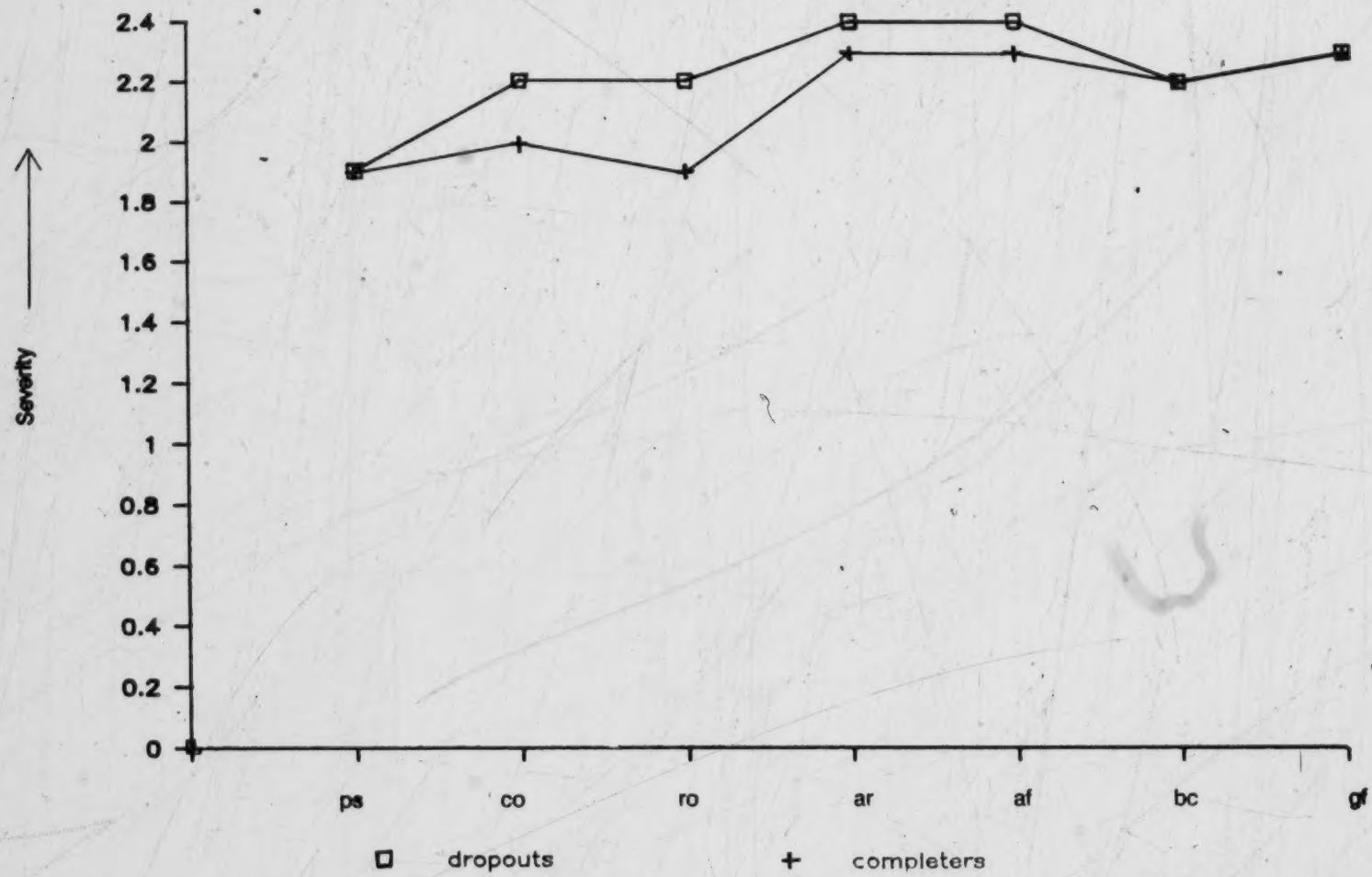


Figure 3b Comparison of Mothers Across Samples on Family Functioning Variables (FAD)

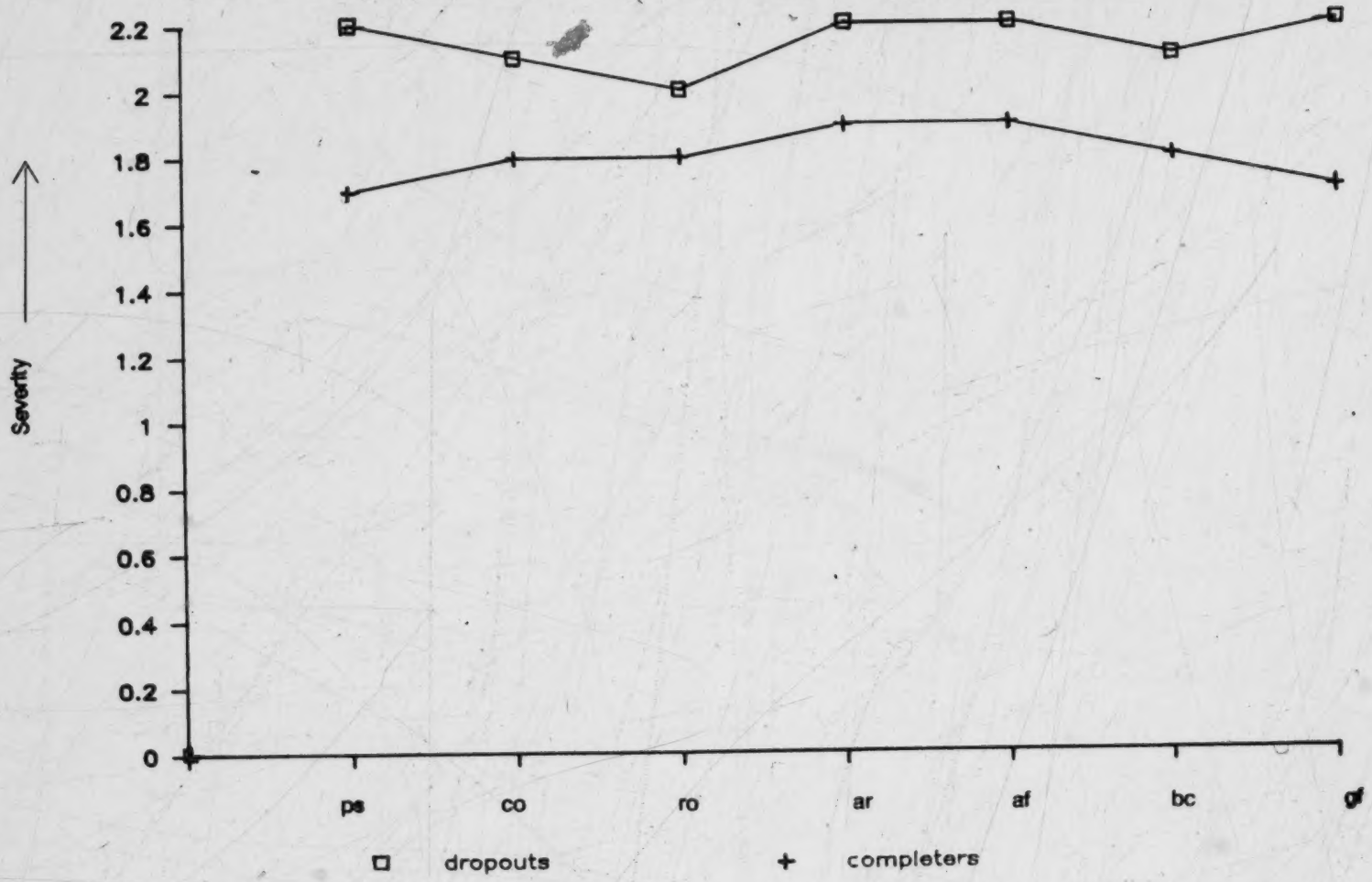


Figure 3c Comparison of Adolescents Across Samples on Family Functioning Variables (FAD)

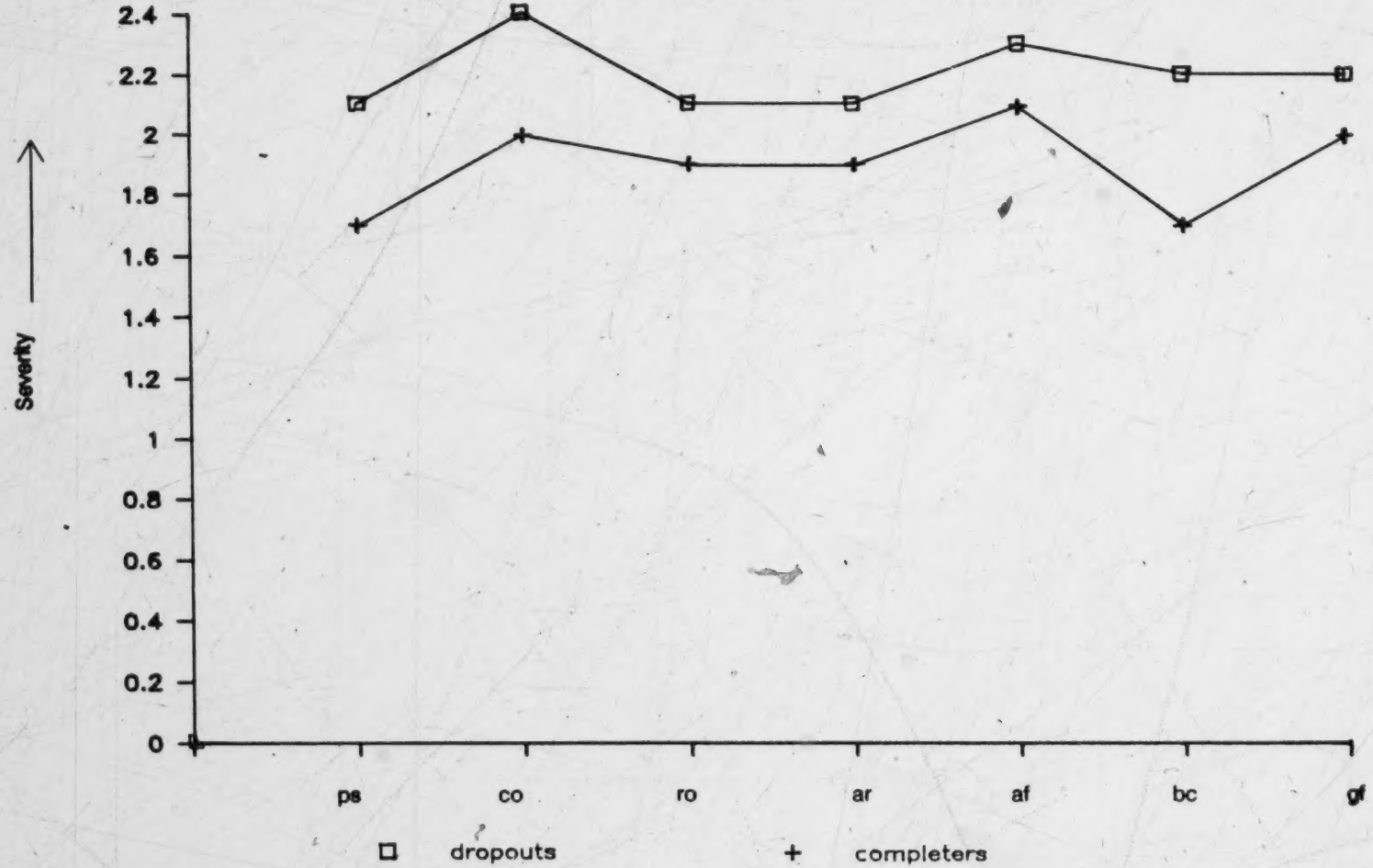
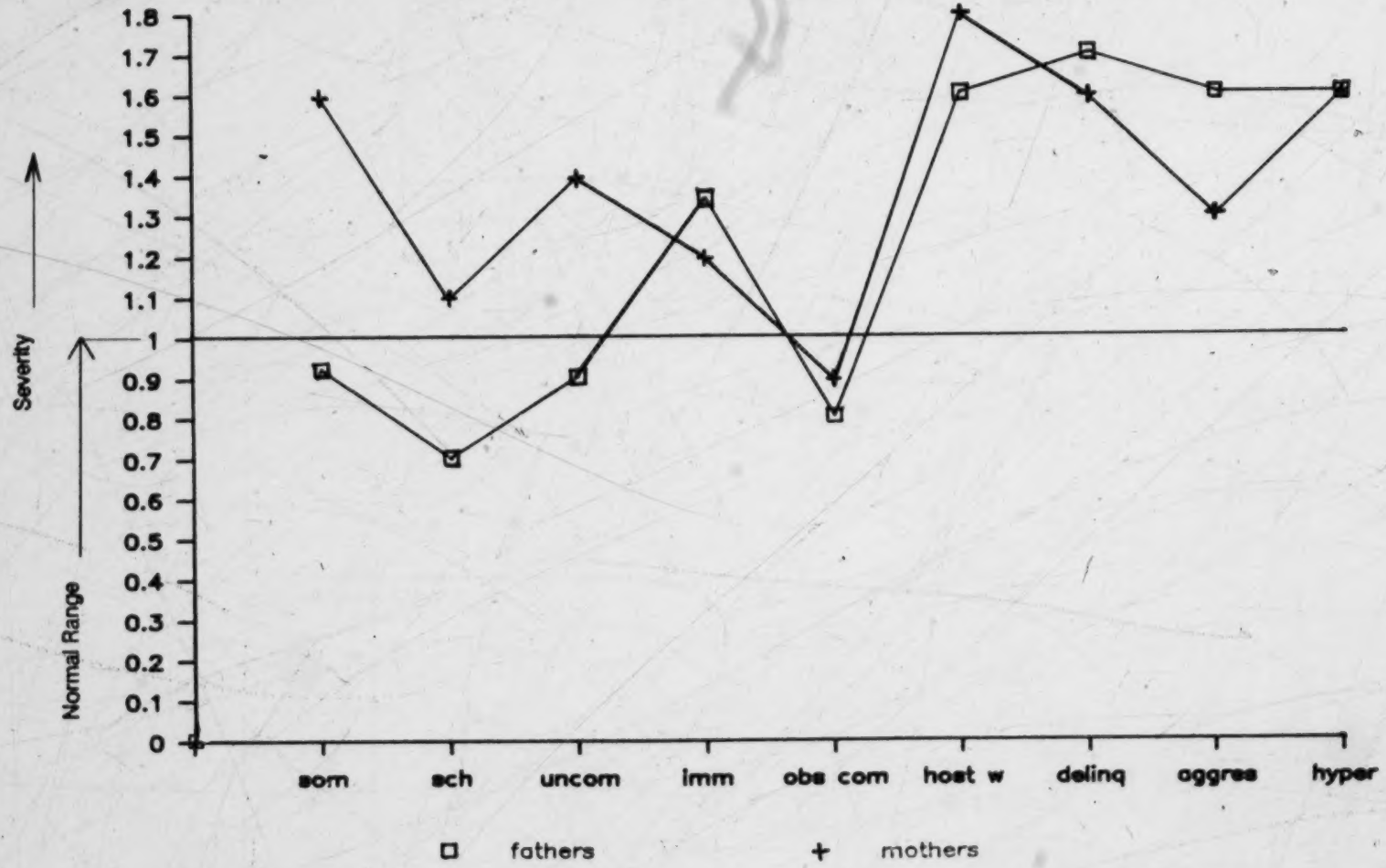


Figure 7a Means of Fathers and Mothers Within Sample (Dropouts) on Adolescent Behaviour Problems (CBCL)



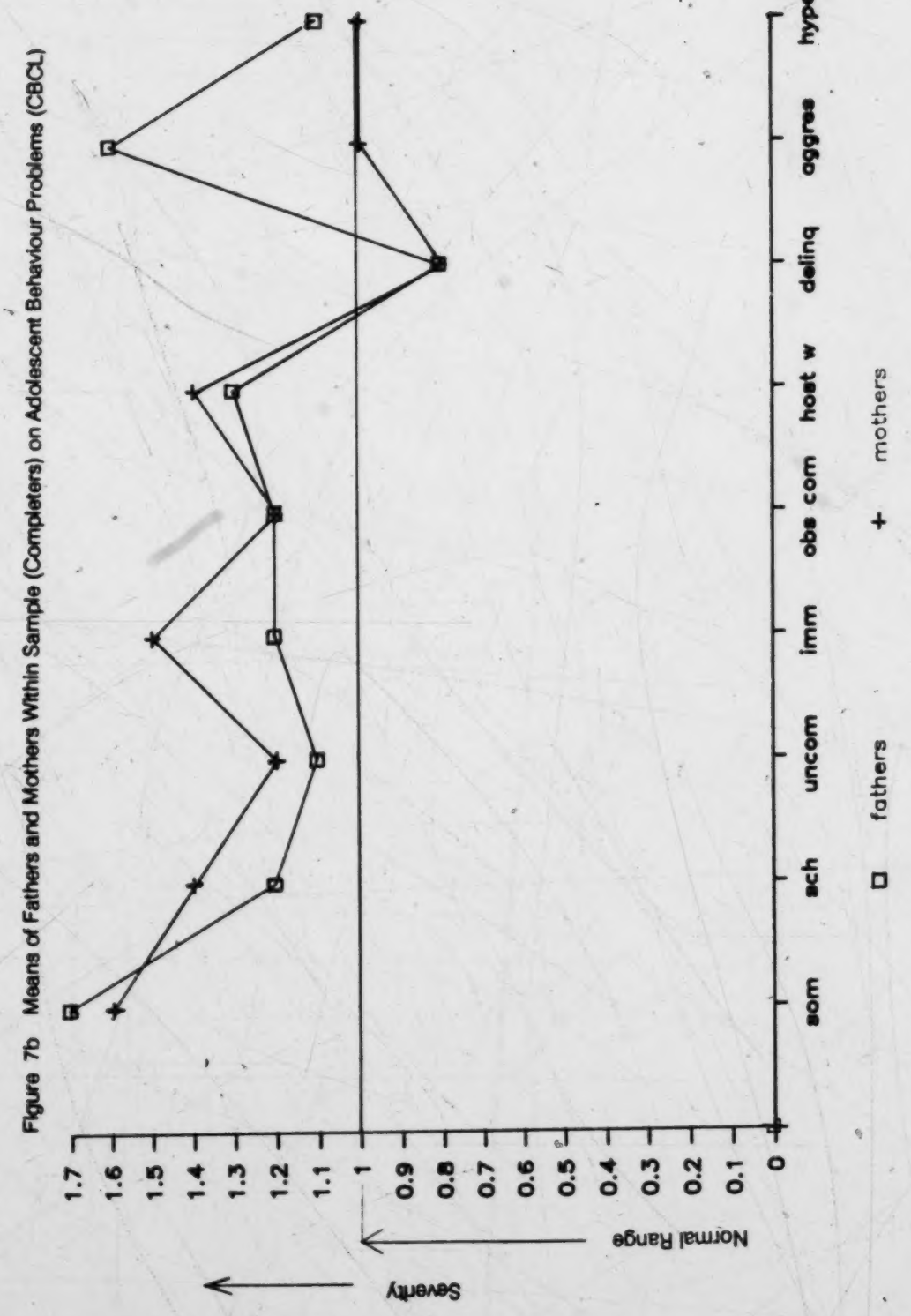


Figure 7b Means of Fathers and Mothers Within Sample (Completers) on Adolescent Behaviour Problems (CBCL)

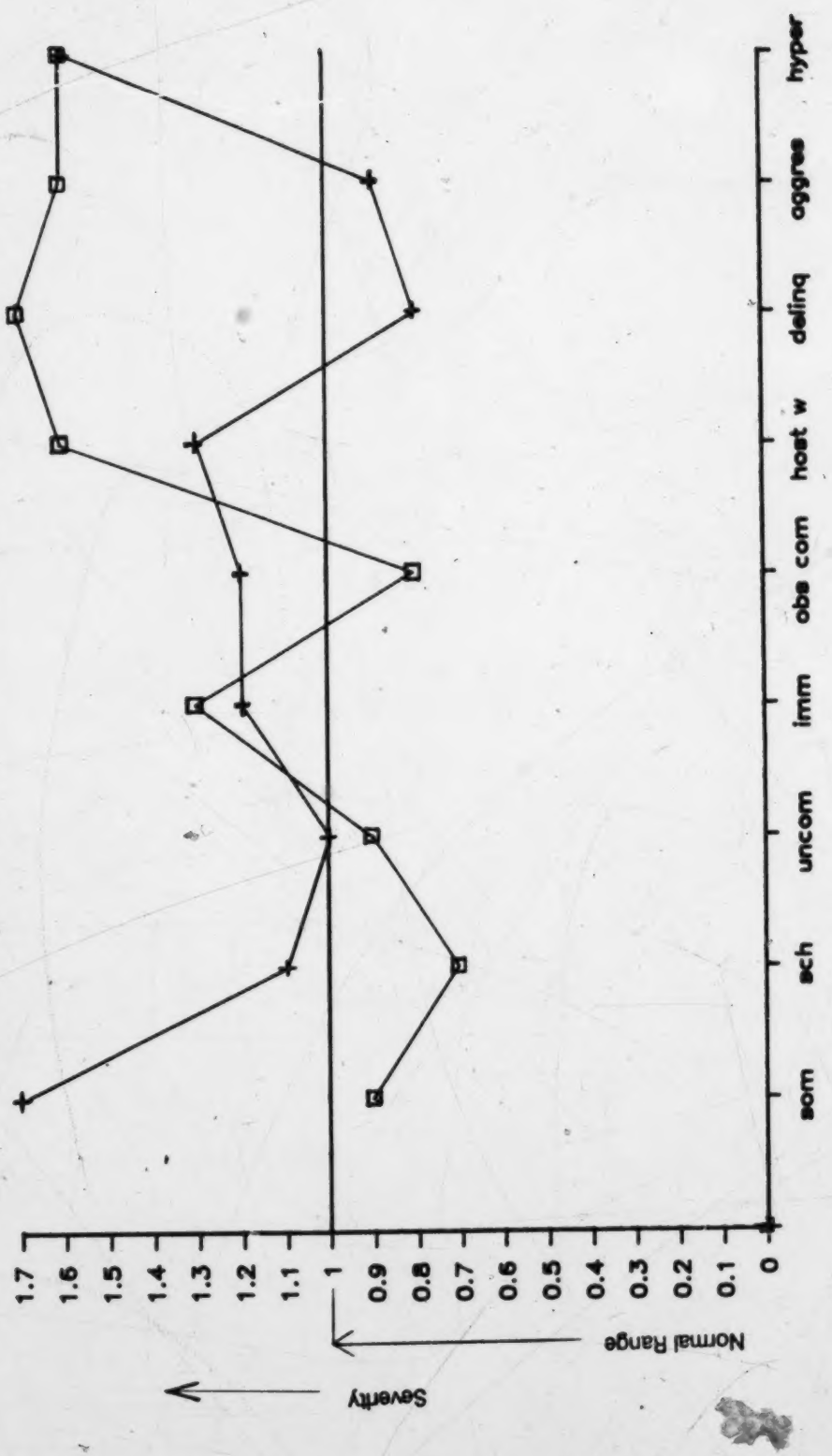


Figure 7c Means of Fathers of Adolescents Across Samples on Adolescent Behaviour Problems (CBCL)

Figure 7d Means of Mothers of Adolescents Across Samples on Adolescent Behaviour Problems (CBCL)

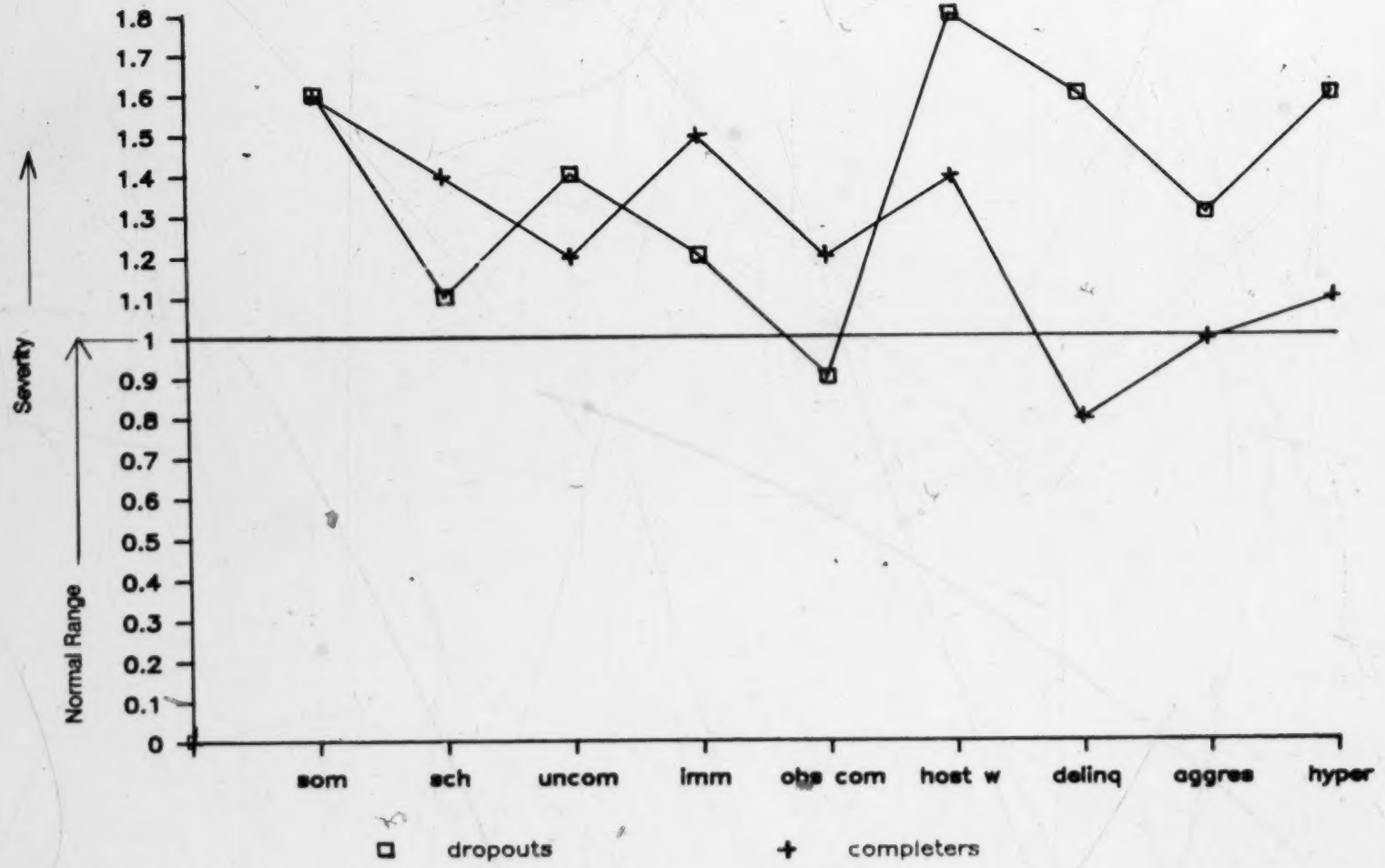
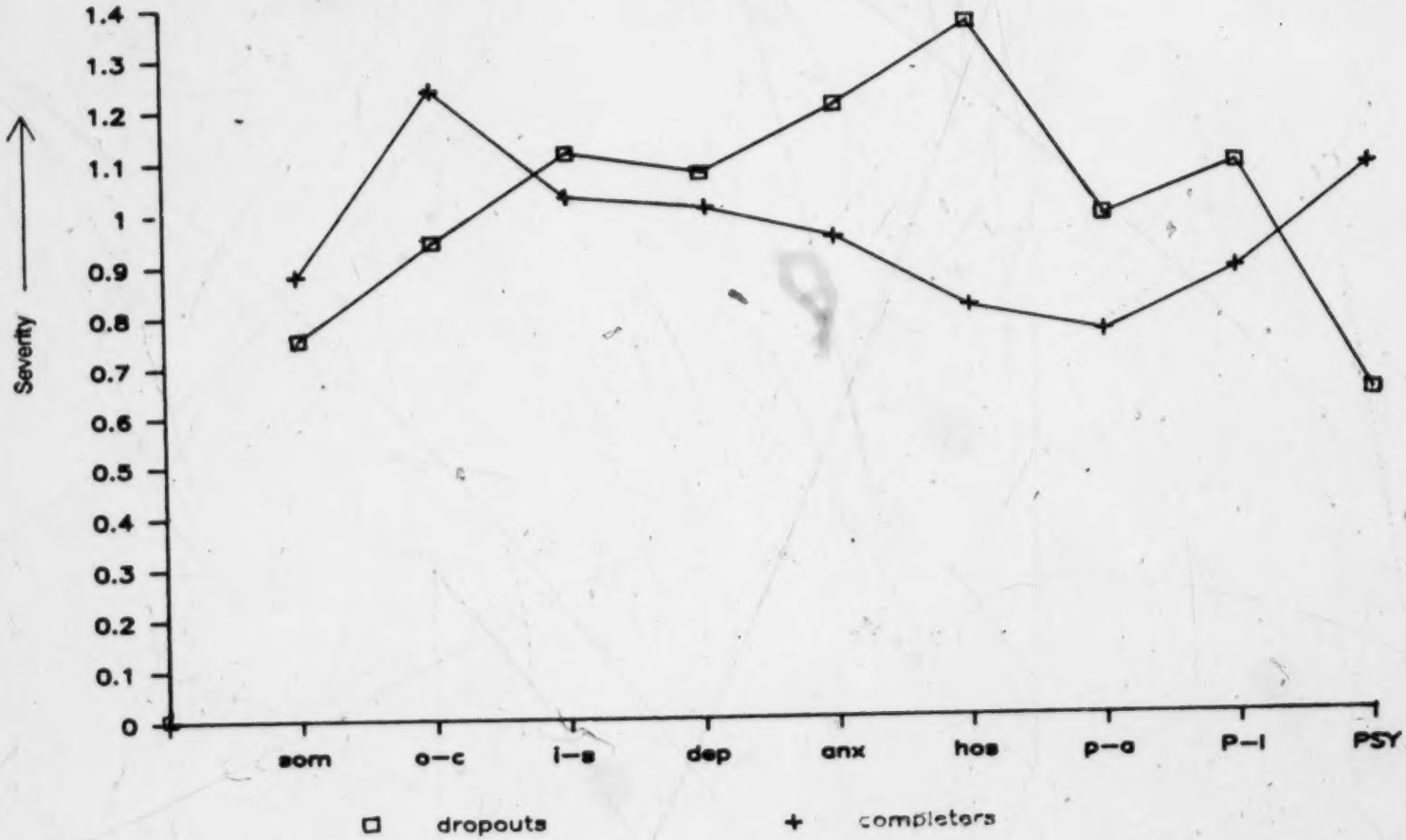


Figure 8a Profile of Means of Severity of Psychopathology of Adolescents (SCL-90 R)



APPENDIX B

A Representative Termination Summary.

TERMINATION SUMMARY OR CONSULT REPORT

Source and Date of Referral: Dr. No. in April

Reason for Referral: Aggressive and self-destructive behaviour, suicidal ideation, poor social skills, low self-esteem, poor academic performance.

TERMINATION Termination Date: 1989 August
YY/MMM/DD

Reason for Termination:

CW (Client Withdrew) — Non-compliance of family to treatment recommendations
Code — Description

Referred to:

SO (Significant Other) — Mr. & Mrs. X., Edmonton, Alberta
Code — Description

Therapist (s): _____ _____
Primary (Name & No.) Secondary (Name & No.)

REGIONAL INFORMATION:

Field 1: _____

Field 2: _____

OPTIONAL Field 3: _____

OPTIONAL Field 4: _____

FINAL DIAGNOSIS (DSM - III or ICD - 9-CM)

AXIS I: 269.2 Major Depressive Episode, in remission

AXIS II: No personality diagnosis

AXIS III: No diagnosis

Code	Description	Order

AXIS IV:

Conflictual relationship with parents - poor peer relationships

Code: 4-severe

Severity

AXIS V: GAF 40

DATA CONTROL

Therapist Signature:_____

Date:_____

Frequency of Contact: Initial assessment in April, started case in May, self discharged in August. Attended 36 of possible 52 days; family kept 4 of possible 10 appointments made.

Types of Treatment: Group and Family Psychotherapy

Psychopharmacology

School Group Therapy

Course and Evaluation of Treatment: Attendance was irregular, with frequent absences and acting out behaviours occuring before family interviews often resulting in cancellation of the latter.

At commencement of treatment patient exhibited high levels of physical activity and restless behaviours associated with reports of martial discord. Patient often had difficulty articulating his feelings and dealing with the affect generated during these attempts. Patient vascillated between blaming himself, then his parents, for problems at home. Attempts at arranging a temporary separation to facilitate treatment was sabotaged by parents. Issues explored with patient included feelings of rejection and sadness associated with his parents' inability to provide the nurturing he needed, some anger at parents' divorce and unresolved feeings regarding the mother's remarriage.

Parents avoided dealing with problems in their relationship and poor parenting skills choosing instead to scapegoat patient and blame him for all the difficulties at home. Colluded with patient to avoid attending interviews. Non-compliance with medication prescribed for patient.

Mental Status on Termination: Evidence of depressive symptomatology, ie. expressions of sadness and hopelessness, withdrawn, no evidence of suicidal ideation.

Medication at Termination:

Pertofrane	50 mg. morning
Neuleptil	10 mg. bedtime

Termination Condition: Poor

Termination Prognosis: Poor

Discharge Plans: Letter sent to social worker documenting program's concern regarding patient's welfare in current living situation and the need for some intervention. Parents also informed of our willingness to reassess patient for returning to program when commitment to program could be adhered to.